			For State Registrar	State of Ma	aryland / I	Departme <i>Certifica</i>			ind Me		giene Reg. Na	004	2850	A.
**	Physici	an	Decedent's Name (First, Middle, Las	•					2	2. Date of De Month	ath 5 <sup>Day</sup>	Y0°4	3. Time of Dea	th
	/Media	al	Mary Elizabe		nt	44.00	-	1 150	(5)	8			12:15	М
Market St.	Examir	er	4a. Facility Name (If not institution, give Prince Georg		tal		, lown, or lever	Location o	r Death			ounty of Deat		
	Funeral	~	5. Social Security Number 6. Se		e (In yrs. last bii	rthday) If Und	er 1 Year	If Under 2	24 Hrs. 8	B. Date of Birt	Pr:	nce (	Georges  Appliace (State or For	reign
	Director		238-44-4139	∃M 2 <b>X</b> F	71	Yrs. Months	Days	Hours	Min.	B. Date of Bird (Month, Da 5	$3^{\gamma_0^{\alpha r}}$ 3	3 NO.	Carolina Carolina	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	m or Location							10d. Inside City Lie	mute
	f sho	٥	MD PRINCE	GEORGES	Kette								1 XYes 2	
	28a-	rect	10e. Street and Number				ip Code				10g. Citize	n of What Co	untry?	
	h with	al Di	12808 Cambleton	Drive		2	0772				_	SA	•	
	72 hours after death with the Maryland Instural', or Hams 23s or 28s-f show Utgal Examilier must be motified at	<b>Funeral Director</b>	11. Marital Status	12. Was Decedent   Armed Forces?	Ever in U.S.	13. Was Dec	edent of Hi	spanic Orig	in? (Speci	ify Yes or No	- 14	. Race - Ame Black, White		
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 <b>X</b> N	10			Specify:	,					
21215-0036	hours tural	q pa	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	160	Donodont's Lle						DI	ack	
7.5	in 72 n "na	Completed	(Specify only highest grad	de completed)		<ul> <li>Decedent's Us (Give kind of w life. DO NOT</li> </ul>	ronk done d	lurina most	of working	7		d of Business/		
212	filed within Hygiene. wher then "	mo	Elementary/Secondary (0-12)	College (1-4or 5	(+)	Monito	r Te	chni	cian		PG	Hosp	ital	
	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the M	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name (	First, Middle,	Maiden Si	umame)		
yla	should that Ment and Ment marked	Tol	James H Loop	er				Ali	ce J	· Gi]	lreit	h		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Itam 27 is marked other than "naturat", or itams 23s or 28s-f show or other traumatic event, the Madical Examiner must be notified at		19a. Informant's Name/Relationship (7 Eldger Wright		19t	. Mailing Addre	ss (Street a	nd Numbe	ror Rural i	Route Number	er, City or T	Town, State, 2	(ip Code) 20772	
	ges 1 and 2 it of Health if itsm 27 is or other tra		20a. Method of Disposition	Ilusball	100	Disposition (N		TCCO.	Da	-				
Baltimore,	Pages nent of I int: If Its iry or o		1 X8urial 2 ☐ Cremation 3 ☐		cemete	ry, crematory or	other place	· 1				ation - City or		
Ħ			*4 □Donation 5 □ Other (Specify  21. Signature of Fulleral Service License		marino	ny Mem			/13/			lover,		
B	permit. Departr Imports eny inj		Man (1	New N	1	B K 420	Henr H St	y Fu	nera NE	l Cha Washi	pel	Inc. n DC	20002	
	100		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death. Do	not enter the mo	de of dying	, such as	cardiac or	respiratory a	rrest,	50	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	E	171 (	ardie	21 /	1	11 L	hmin			Onset and Death	1
100	/Medical Examiner		resulting in death)	Due to (or as	a consequence				4 1	IIIId				
	w w	L	Sequentially list conditions if any, leading to immediate	b										
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):								
	xecul and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):								
8760,	icate be executed physician and s the burial-transit	cal		d										
89	tificat ig phy as thi	ledic		o										
Вох	eath certific attending p	Physician/Medi	230. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		n 3 ⊟Ectopic	nregn ancy				23	d. Date of deli	very	
о. Ш	he att	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at		5 ☐ Other (s						Month	Day Year	
ص ن	ires that the de signed by the a i be detached f	Phy	9 Unknown							00 0:11				_
ds,	The law requires that the death certific tie has been signed by the attending page 2 should be detached for use as:	þ	Part II. Other significant conditions co	intributing to death b	ut not resulting i	n the underlying	cause give	n in Part I.				No 3 Pr	the cause of death	
	w requir been si should	etec												
Vital Records,	he lav	Completed								24a. Was autor perfo	osy	24b. Were au prior to d death?	topsy findings avail completion of cause	able of
	ifficate or. pa	e Co	25. Was case referred to medical					00 Di	-4.0		rmed? 2 No	1 Yes	2 No	
	Attanding Physician: r death. ector: After this certification the funeral director.	0 0	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ER/O	utpatient 3 0	OA Othe			Check only o		□Other (Spec	nife)	
0	neral	n; T	27. Manner of Death	28a. Date of Inju. (Month, Da	ry 28b.	Time of	28c. Injury Work			d. Describe			niy)	
Sio	uttandir death. ctor: Af r the fu	atlc	1 Natural 5 Pending 2 Accident investigation	(	, , ,	М		res 2 □ N	No					
Division of	after d Direct in by t	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At home, fa c. (Specify)	arm, street, facto	ry, office		28	f. Location (3 City or Tox	Street and i	Number or Ru	ral Route Number,	
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 15d Certifying Phy	reiniana V. W. L.	of must	<u> </u>								
	• Hospitel 24 hours 2 • Funerei etely filled	edical	(Check only one) (Check only one)	rsician: To the best of iner: On the basis of and manner sta	examination ar	e, death occurre nd/or investigation	d at the tim n, in my op	e, date and inion, deat	d place, an h occurred	d due to the at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)	
0	To the within 2. To the complete	Me	29b. Signature and little of certifier	/	Α.	2	9c. License	number			29d. Date	signed (Montl	n, Day, Year)	<del></del> -
			1/1/ 1/1	ItA, 1	nl	1	14.8	94	7			8/11/2	4	
1	1		30. Name and address of person who o	ompleted cause of d	eath (Item 23a)	(Type, Print)	<u>, 0</u>	10				טןיוןכ	7	
人	1/2/		Dr. Bary L	He	3001	HOSP	112/	DI	_CVI	evento	1 M	1.0	30785	_
	Sta		31. Date filed (Month, DAy, Year) AUG 2 6 2004	32. Registra	ar's Signature	1.0				/	/		,	
	Registi	(21)	HUU A U LUUT	2 17 M. P. L. J	AP L	The state of						4		

			1_ For State	State of Maryla	nd / Depa	artment of H	ealth and			•	
			Registrar		Ce	rtificate of L	Death		Reg. No	2004	<u> 28502</u>
	Physici	an	Decedent's Name (First, Middle, Las					2. Date of D Month		Y Year	3. Time of Death
	/Medio			ing				Aug. 2	21,2	004	12:05A
	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, or		ath	4c	. County of Dea	th
			National Lut				kville		M	ontgom	ery
d	Funeral Director		2.7 01 2012	9.2 3 3 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	s. last birthday) Yrs.	Months Days	If Under 24 Hr Hours Mir		irth Pay Year) 9 , 1	9. Bin 912 Ma	thplace (State or Foreig puntry) laysia
9	3		Usual Residence of Decedent  10a. State 10b. County	100 (	City, Town or Lo	ocation					10d. Inside City Limits
Mary	a or 28a-f show	Director	Md. Monto	omery		Rockvi	lle				1 X Yes 2 □ No
5-0036 72 hours after death with the Marvland	23a or 2 uni be n	al Dire	10e. Street and Number 9701 – Veirs	Drive		10f. Zip Code 208.	50		10g. Ci	tizen of What Co USA	ountry?
dea	SE E	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (	Specify Yes or N	0-	14. Race - Ame	
U36 ours after	iral', or items 23a c	ρ	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	nto moan, etc.,		Specify: C	hinese
7275-C within 72 h	iene. rthan "natur the Wedical	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	ition luring most of w	orking	16b. K	and of Business	Industry
d 21	Hygien ther th	ő	12		A	cupuncti	ırist			Healt	h
⊆ 8	a d a	To Be	17. Father's Name (First, Middle, Last) Chan Nyuk					ame (First, Middle Gui Yi			
	h and 7 is my traum		19a. Informant's Name/Relationship (7 David Wang-	ype, Print) Son		ng Address (Street a					Zip Code) Md • 20878
ē, 5	item 2 other		20a. Method of Disposition	I .	Place of Dispo	osition (Name of matory or other place	a)	Date	20c. L	ocation - City or	Town, State
mor Pages	ent of nt: If i		1 □XEurial 2 □ Cremation 3 □  `4 □ Donation 5 □ Other (Specify			Wash . Cer		7/2004	Ad	elphi,	Md.
Baltimore,			21. Signature of Funeral Service Licen	see		2. Name and Addres Hysong (	Tno	c.			
		_	23a. Part1. Enter the disease, or conshock, or heart failure. List only	dications that caused the de	ath. Do not ent	6510-161	h St.	NW, Wa	sh.	, DC	Approximate
-			shock, or heart failure. List dnly o Immediate Cause (Final	one dause on each line.		, ,		,			Interval Between Onset and Death
	nysician /Medical		disease or condition resulting in death)	a. PNEUH							
	xaminer			Due to (or as a conse	T 100 000						
		<u>ا</u>	Sequentially list conditions,	b. Lette (5) A		ULAR	ACCIO	CNI			
Det Det	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0.		010					
<b>5U,</b> be executed	and al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as a co se	equence of):	DISOLOLO	-				
/60, 888.	ician	calE		d. DIMENT	T) in -						
	phys s the			d. VIIIEVO	1,000						
death cert	attending physician and dor use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of	tal death 3	Ectopic pregnancy Other (specify)				23d. Date of del Month	ivery Day Year
	by the tached	hys	9 □ Unknown	9□ Unknown							
dS, r	signed b	by	Part II. Other significant conditions co	entributing to death but not re	esulting in the u	nderlying cause give	n in Part I.				the cause of death?
ວ ຊຶ	been s	ete						24a. Was		045 144	A
		Completed						auto perf		prior to death?	topsy findings available completion of cause of 2 No
iciar V	certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		0.11		eath (Check only			
OT VITA Physician:	this al dir	ဥ	1 195 2 NO	1 Linpatient 21	☐ ER/Outpatier		4 (Aursing	Home 5 ☐ Res			cify)
	ي قِيقِ	on	27. Manner of Death 1   Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe	how injur	y occurred	
VISION	tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be				′es 2 □ No		,		
- ö	s after death. el Director: Al ed in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location City or To			rai Route Number,
L the Hospitel	4 IT A	Medical (	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the tim vestigation, in my op	e, date and place inion, death occ	e, and due to the curred at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
Tot	within 2 To the complet	X	29b. Signature and title of certifier			29c. License	number		29d. Dat	te signed (Monti	n, Day, Year)
			> Wheeter au	4.0		D000	51158		AUG	UST 2	1 2004
^	0 6	1	30. Name and address of person who d		em 23a) (Type						
C	4		VATTITE ANTH		VEIRS		ROCK	りししど	nr	2085	6
19	Sta Registr		AUG 2 6 2004			S. 1					

			For State		ryland / Depa						- 0	1000	20500
			Registrar Amend#1 & 2  1. Decedent's Name (First, Middle, Last	)				Jean (		. Date of Dea	Reg. No	UUA	3. Time of Death
	Physici			Austin	Luellan	Youn	g			Month	Day	•	
<b>(</b> -	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, 1	Town, or	Location of D		August		2 200 County of Dea	
			Frederick Memo	rial Hos	pital	Free	deri	ick				Freder	ick
	Funeral		Social Security Number     6. Se		(In yrs. last birthday)			If Under 24		8. Date of Birth			rthplace (State or Foreig ountry) yland
	Director		Usual Residence of Decedent	JM 20 F	80 Yrs.		,.			Feb. 26	5, I	924 Mar	yland
	land w		10a. State 10b. County		10c. City, Town or Lo	ocation							10d. Inside City Limits
	Mary f sh	to	Maryland Frederic	k	Thurmont								1 ☐ Yes 2 No
	n the	lec	10e. Street and Number			10f. Zip	Code				10g. Cit	izen of What C	ountry?
	th wit	a D	13917 Graceham Ro	ad			2178	8				U.S.A	1.
	72 hours after death with the Maryland natural', or Items 23s or 28s-f show Jigal Examinan insales mullind at	by Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decede	ent of His	spanic Origin	? (Spec	city Yes or No-		14. Race - Am Black, Whi	
36	or It	YFL	1 Never Married Married	1 ☐ Yes 2 ☑ No If Yes, Give	0	1 ☐ Yes 2		Specify:	0011011	, 0(0.)		Specific	
Ş	hours tural	d be	3 Widowed 4 Divorced	Year or Dates:	160 Day	death Herry	10	**			151 15	V	White
21215-0036	in 72	olete	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	dent's Usual kind of work DO NOT use	l Occupa k done di e retired)	tion u <i>ring m</i> ost of	f workin	g	16b. Ki	ind of Business	s/Industry
212	d within piene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Fore				1	Моо	re Busi	ness Forms
	be filed ital Hygir d other event, t	BeC	17. Father's Name (First, Middle, Last)					18. Mother's	Name	(First, Middle,	Maiden	Sumame)	
<u>a</u>	should be ind Mental I marked o	To	Earl S. Young				:	Mae Bo	wer	S			
Maryland	2 sho and I s me		19a. Informant's Name/Relationship (7)									r Town, State,	
	1 and Health em 27 Ither tr		Betty L. Young (Wi	Lie)								ryland	
Baltimore,	ges 1 it of H if Ite or ot		20a. Method of Disposition  1 XBurial 2 Cremation 3 F	Removal from State	20b. Place of Dispo cemetery, cres	matory or ot	ne of ther place	9)	Da			ocation - City or	
E E	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Marylar Hygienal Hygienal. Important: if Hem 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Marical Examination into the indifferent and page.		' 4 □Donation 5 □Other (Specify)		Resthaven								Maryland
Ba	permi Depa Impo any ii		21. Signature of Uniteral Service Cicens	Tailer	01	5 EAS	T MA	TN STR	KEET.	, THURM	10NT	HOMES,	P.A. 788
>	Physician /Medical		23a. Part1. Inter the disease, or composhock for heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. 114 A	T f	for the mode	of dying	M.		respiratory arr			Approximate Interval Between Onset and Death
	Examiner			Due to (or as a	consequence of):	Ali	10	S Agus	to T	ubular	Mag	monia	0475
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):	1100		Acut	LE I	ubutai	Nec	10818	01)13
8760,	rate be executed hysicien and the burial-transit	I Exar	that initiated events resulting in death) Last	CDue to (or as a	consequence of):								
200	physic physic s the b	edlcal		d									
X 6	certifi iding se as	/Me	IF FEMALE:	23c. If yes, outcome o	of pregnancy								
O. Box	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Petal death 3□	⊒Ectopic pre ⊒ Other (spe						23d. Date of de Month	Day Year
Records, P.	ires that the de signed by the a d be detached f	by	Part II. Other significant conditions co	ntributing to death but	t not resulting in the u	ndertying ca	iuse givei	n in Part I.		23e. Did tol		,	o the cause of death?
Ö	w requir been si should	etec							_	-			
ě	0 - 0	Completed								24a. Was a autops perform	sy	prior to death?	utopsy findings available completion of cause of
_	iiclan: Th certificate rector, pag	e Co	25. Was case referred to medical					20 71 /		1 ☐ Yes 1	No.	1 □ Yes	2 □ No
Vital		To Be	examiner?	Hospital: Inpatien	nt 2 ER/Outpatier	nt 3□ DO/	Other	r		Check only on		6 □Other (Spe	- (1)
	ig Phye ter this heral di		27. Manner of Death	28a. Date of Injury	28b. Time of		Bc. Injury			d. Describe h			icity)
0	ith. : Aft	.0	Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	М		es 2□No					
DIVISION	2 6 5 2	a	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	ry - At home, farm, str. (Specify)	eet, factory,	office		28	St. Location (St City or Town	treet and	d Number or R	ural Route Number,
$\supset$	r Attending ter death. irector: After by the fune	tificat	4 Homicide determined	building, etc.						,			
	oital or Atter urs after dea aral Director illed in by the	Certification:	4 Homicide determined										
	he Hospital or Atter in 24 hours after dea he Funeral Director pletely filled in by the	edical	4 Homicide determined  29a. Certifier 1/2 Certifying Phy	sician: To the best of ner: On the basis of and manner stat	examination and/or in	h occurred a vestigation,	at the time in my opi	e, date and p inion, death o	lace, an	nd due to the ca	ause(s) late and	and manner as place, and due	s stated. a to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		4 Homicide determined  29a. Certifier (Check only Medical Exami	sician: To the best of	examination and/or in	vestigation,	at the time in my opi License	inion, death o	place, an	d at the time, d	late and	l place, and due e signed (Mont	to the cause(s)  th, Day, Year)
	To the Hospital or Atter within 24 hours after dea To the Funeral Director completaly filled in by the	edical	4 Homicide determined  29a. Certifier (Check only one)  29 Medical Exami	sician: To the best of	examination and/or in	vestigation,	in my opi	number	elace, an	d at the time, d	late and	place, and due	to the cause(s)  th, Day, Year)
37	To the Hospital or Atter within 24 hours atter dea To the Funeral Director completely filled in by the	edical	4 Homicide determined  29a. Certifier (Check only one)  29 Medical Exami	sician: To the best of iner: On the basis of and manner state	examination and/or in	vestigation, 29c. D	License	number	occurrec	d at the time, d	late and	l place, and due e signed (Mont	to the cause(s)  th, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year VIRGINIA LONA SEPTEMBER 3, 2004 6:10 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARINER HEALTH OF FOREST HILL HARFORD FOREST HILL

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 38 -1 ☐ M 2 🗹 F 895 86 Director Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Evandiner must be notified at Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or itams 23a Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iten any injury or other traumatic event, it is the lical Evantral and. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Whis þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Be Maiden Sumame ۵ 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Other (Specify) 4 Donation 21. Signature of Funeral Service Licenses 22. Name and Address of Facility EVANO Funeral Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Medical Certification; To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day 4☐Pregnant at time of death Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be 1 Yes 2 No 3 Probably 4 Honknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes Cther: 4 Nursing Home 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA completely filled in by the funeral dir 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Diaturai 2 Accident 5 Pending after death. investigation 2 🗌 No Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 MacPHAIL ROAD BEL AIR, MD. 21014 DAVID DUNN 31. Date filed (Month Day Per 0) 9 2004 strar's Signature State Registrar

		4	For State Registrar	State of M	arylar			nt of H te of L		and M	ental Hy	giene Reg. No	2001	2	2850	16
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	Maryland -f show		Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Ar	undel	10c. Ci	ry, Town or Lo								10d	I. Inside City I	
	h with the 23a or 28a at be noti	Funeral Director	10e. Street and Number	Sedge Co	ourt	*	10f. Zi	p Code	21122			10g. Ci	tizen of What	t Country	y?	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "naturel" or items 23a or 28a-f show important: If item 27 is marked other than "naturel" or items 23a or 28a-f show important: If item Medical Examinar moral be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Tyes 2 1 If Yes, Give Year or Dates:	? No		Was Dece If Yes, spe 1 Yes		spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	D-	14. Race - A Black, W Specify:	Vhite, etc		
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3altimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tri once.		20a. Method of Disposition 1 □ Burial 2 🖫 Cremation 3 □ 1 □ Donation 5 □ Other (Special	y)	Ba	Place of Dispo cemetery, crea yview	matory or Crema	other place itory	, Inc	. 9/		Ba1		e, Ma	n, State aryland	d
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36	or ite	by Fune	Marital Status     Never Married 2 Married     Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub I □ Yes 2 No	Hispanic Origin? (S lan, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	- 14. Ra	ce - American ack, White, etc	c.
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	13		30. Name and address of person who	completed cause of death (Item	23a) (Type, F	Print)	11.1 (			?	24
	Sta	40	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture	1 000	Med Con	-	200 44	M.	2/104
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Heinz Balasus September 5,2004 10:55 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Genesis Heritage Meridian Care Ctr. Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign OXXM 2□F June 5,1922 Director 214-12-2240 82 Germany Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits or 28a-f show Examiner must be notified at Baltimore Dundalk Maryland 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23c 1904 Denbury Drive 21222 United States by Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2√☐ No Specify: Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Machinist Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental is markad Eduard Franz Balasus Dora Sofie Kauffeld 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other trau Mr. Michael Balasus / Son 1944 Stanhope Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 9/8/2004 Oak Lawn Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. egorn 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the divise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart fail re. In ne cause on each line. Immediate Cause (Final disease or condition resulting in death)

a. Due to or as a consequence of the condition resulting in death) Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transil attending physician and Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has certificate 1 ☐ Yes 2 1 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 ☐ Yes 2 No 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funaral Director: After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred To the Hospital or Attanding 1 Natural 5 Pending Injury investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) SEPTEMBER Day 2004 **Physician** FAITH BURKE 11:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL GLEN BURNIE CRANBERRY COTTAGE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | FEB. 25, 1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2 F 74 MARYLAND 213-26-0470 Yrs. Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State item 27 is marked other then "naturel", or items 23a or 28e-f show other treumatic event, the Mudical Examiner must be notified at ANNE ARUNDEL GLEN BURNIE MARYLAND 1 Yes 2 No Director 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 7820 OAKWOOD ROAD 21061 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status permit. Peges 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or iten any injury or other treumatic event, the Medical Experimenance. Black, White, etc. 1 Never Married 2 Married WHITE 1 Tes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN JACOB BLOTTENBERGER ANNA MAE CARLYISLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CHARLES H. BURKE JR. - HUSBAND 7820 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition SEPTEMBER 20c. Location - City or Town, State 1 🔏 Buffai 2 □ Cremation 3 □ Removal from State GLEN HAVEN MEM. PARK 9, 2004 GLEN BURNIE, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee KIRKLEY KUDDICK FUNERAL HOME P.A. 421 CRAIN HIGHWAY S.E. GLEN BURNIE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Metastan nonsmall cellling cance year /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Pres 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2□ No certificate 2 1No 1 Tyes To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 372915D Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 COther (Specify) 2 1 ☐ Yes 2 ☐ M6 this INDUST. 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident I Director: d in by the f 6 ☐ Could not be 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifies cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier h who completed cause of death (Item 23a) (Type, Print) Bulkmore Mary 300 32. Registrar's 9 31. Date filed (Month, Day, Year) State SEP 0 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7:55A.M **Physician** Zabeth Rewster UNE 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner sardens HIMOR Hartorc 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 💢 F Months Days Hours 215-24-577 Usual Residence of Decedent Director with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other then "naturel", or items 23e or 28a-f show other treumstic event, If a Nedical Eranni or must be notified at 1 Yes 2 □ No MD BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ISA 21214 4700 Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ont: If item 27 is marked other then "naturel", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White. 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) per 10100 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be PANK atherine Hogan Lam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town) State, Zip Code) 19a. Informant's Name/Relationship (Type, rint) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other treu QDCs. Gilland brother MO 21236 saltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 9-7-04 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Ficility BALTIMORE, MO 21234 complications that caused the difath EVANS FUNGRALCHAPEL. 8800 HARFORD RD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. List Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner to the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical use a IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Proknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy 2 **X**No 1 Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P this Director: After thi Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel I 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a Certifie 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

MIMI

SEP 0 9 2004

31. Date filed (Month, Day, Year)

30. Nam 2 d address of person who completed cause of death (Item 23a) (Type, Print)

GENERA

32. Registrar's Signature

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			1 - For State Registrar	State of Maryland /	Department of He			2001	20510
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**	Physici /Medic	cal	ETTIE Jui  4a. Fecility Name (If not institution, give	ne Blevin	4b. City, Townwor		2. Date of Death	1, 200	45,42 HM
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	uneral Director		017-27-2101	ex 7. Age (In yrs. last b	ointhday) If Under 1 Year Months Days Yrs.	If Under 24 Hrs. Hours Min.	8. Dale of Birth (Month, Day, Ye 2-14-3	ar) 9. Bir	thplece (State or Foreign ountry)
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o .	O == =		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Specify	Removal from State 20b. Place cemet	of Disposition (Name of tery, crematory or other place	e/ 9-2		Location · City or	
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OT VITAL	is certificete director, pag	o Be	25. Was case referred to medical examiner?	Hospital: ↑ ☐ Inpatient 2 ☐ ER/O	Other	26. Place of Death	(Check only one)	6 □Other /Sne	c(fv)
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DIVISION itel or Attending	within 24 hours after death.  To the Funerel Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify)			281. Location (Street City or Town, St	ate)	
dsoH e	Funer Funer etely fill	edical	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my knowledg niner: On the basis of examination a and manner stated.	ge, death occurred at the time and/or investigation, in my opi	e, date and place, a nion, death occurre	nd due to the cause od at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
To th	To th compl	Me	29b. Signature and title of certifier	+ 11/20	29c. License	number	29d.	Date signed (Mont)	h, Day, Year)
	\		30. Name and address of person who	continued by the court (Item 23a)	(Type, Print)	4336	He custal	eptente	1,2004
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		1	For State Registrar		State of Ma	•	epartment of Certificate	of Health and of Death		giene Reg. No.()	nni.	29512
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	Examin		4a. Fecility Name (I	f not institution, gi	ve street and number)		4b. City, To	vn, or Location of De	ath	4c. Co	ounty of Death	
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	Funeral	- 1	5. Social Security N 218–30–71		Sex 7. Age 1 ☐ M 2 ☑ F	(In yrs. last birti		ays Hours Mi		y, Year)	6 New	place (State or Foreign htry)
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	yland now		10a. State	10b. County		10c. City, Town	or Location				1	0d. Inside City Limits
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	or 28s	Directo	10e. Street and Nu	mber			10f. Zip Co	de		10g. Citize	n of What Cour	ntry?
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	tems	Funeral	11. Marital Status		12. Was Decedent I Armed Forces?		13. Was Decedent If Yes, specify	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14	Race - Americ Black, White,	
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Baltimore,	m O		1 Burial 2	☐Cremation 3	Removal from State	/	Disposition (Name y, crematory or othe	l l				
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ř			mediate Cause	(Final	y one cause on each lir	18.	Para	Bob och	~ Pulleus	and A	Rear	Interval Between Onset and Death
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o	g Physer this eral di	E H	27. Manner of Dea	ith	28a. Date of Inju (Month, Da	ry 28b. 1	Time of 280	Injury at Work?	28d. Describe			
<u>o</u>	nding l ath. r: After e funer	atlo	1 Natural 2 Accident	5 Pending investigat		y (64)	njury M	1 ☐ Yes 2 ☐ No				
<u>N</u>	or Attencafter death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 286. Place of inj	ury - At home, fa c. (Specify)	rm, street, factory,	office	28f. Location ( City or To		Number or Run	al Route Number,
ā	s after s after el Dire	Cert	4 1 10 110 100									
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier (Check only		Physician: To the best aminer: On the basis o							
	To the H within 24 To the F complete	Medical	one)		and manner st	ated.			1			
	To To To	2	29b. Signature and	d title of certifier	a -		29c.	icense number		290. Date	signed (Month,	OL
	^		1/1	nchi				MYDY		0	100	_ 07
	il		30. Name and add	tress of person with	completed cause of c	leath (Item 23a)	(Type, Print) 701	3 Mounta	in Rd F	'asad	ona M	D 21122
J.		210	31. Date filed (Mo	onth. Dav. Year)	32. Registr	ar's Signature	4 -> 100	> 14 C A COL (   W	11100	الله: حال	will.	3.71-01
	Regist	ate rar		P 0 9 200			rock					
DH	HMH 17 Rev 1/2		UL		- KANDERS J	No May						

**ORIGINAL** 

			1 - For State Registrar	State of Ma	ryland		artment rtificate			ind M	-	giene	1001	28514
	Dhysisi	on	1. Decedent's Name (First, Middle, Las	,					•		2. Date of De		Year	3. Time of Death
	Physici /Medi		Thelma	Р.		Br	own				09°-0			3:30 A M
	Examir	ner	4a. Facility Name (If not institution, give Southern Mar		cni+=	s 1	4b. City, To	wn, or L into		Death		4c.	County of Death	
			5. Social Security Number 6. S		(In yrs. last		If Under 1		If Under 2	4 Hrs.	8. Date of Bir	th	O. Rietu	lace (State or Foreign
	Funeral Director			□M 21√xF	84	Yrs.			Hours	Min.	8. Date of Bir (Month, Da Sept.	ÿ. Y <sup>e</sup> ar)	, 1919 our	N C
	g ,		Usual Residence of Decedent		10c. City, T						•			
	shov	5	10a. State 10b. County		•								1	0d. Inside City Limits 1X Yes 2 □ No
	28a-f	Director	Md PG		U I	into	10f. Zip C	ode				10a Citi	izen of What Cour	
	3a or		9106 Pine Vie	w Lane				20				.09.04	US	
	death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13.	Was Deceder	nt of Hisp	panic Orig	in? (Spe	cify Yes or No Rican, etc.)	-	14. Race - Americ	
98	or Its	y Fu	1 Never Married 2 Married	1 ☐ Yes 2X N If Yes, Give	0		1 ⊡ Yes <b>X</b> ⊡		Specify:	ruenoi	nican, etc./		Black, White,	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "netural", or Itams 23a or 28a-f show event, it is Medical Everalise medified at	ed by	3X Widowed 4 □ Divorced  15. Decedent's Ed	Year or Dates:	1	6a Daga	dent's Usual (					105 1	DI	ack
5.	in 72 n "ne	Completed	(Specify only highest gra	de completed)		(Give	kind of work DO NOT use	done dur retired)	ring most	of workii	ng .	160. K	ind of Business/Ind	dustry
212	filed with Hygiene. thar thar ant, the M	lmo	Elementary/Secondary (0-12) 6th	College (1-4or 5-	<b>+</b> )		Eleva	tor	0pe	rat	or	F	rivate	Industry
2	al Hy a othe	Be	17. Father's Name (First, Middle, Last)	_				1:	8. Mother	_	(First, Middle,	Maiden	Sumame)	
yla	2 should be filed withir and Mental Hygiene. Ia marked othar than aumatic event, II e M	To	Joseph		ather						nes			
Maryland	s 1 and 2 should f Health and Men itam 27 la marke othar traumatic		19a. Informant's Name/Relationship (7									-	r Town, State, Zip	
	of Health itam 27 othar tr		Annie G. Als 20a. Method of Disposition	ton (dau	20b. Place	e of Dispo	sition (Name	of		τ.	upper	191 a Y	CIDOYO ecation - City or To	Md ZU//Z
JOH	0 0		Y☐\Burial 2 ☐ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Specify		Resu	atary, crai JYYE	natory`or othe ction	er place) Cer	mete	ry	09-08		Clinto	
Baltimore,	permit. Page Department Importent: I any injury o		21. Signature of Funeral Service Licen						1				lome, I	
Ö	Depa Impo any ir		Z		)								sh. DC	
			23a. Part 1. Enter the disease, or companies, or heart failure. List only	olications that caused one cause on each line	the death. [									Approximate Interval Between
-	Pnysician		Immediate Cause (Final disease or condition	a. Prus	OLL	OK	IA							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequen	ce of):								
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequen	ce of):								_
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			,								
o,	an an rial-tr	Exa	resulting in death) Last	Due to (or as a	consequen	ce of):								
8760,	cate be executed oblysician and the burial-transit	dlcal		d				,						
ox e	The law requires that the death certificate be executed the face of signed by the attending physician and oate 2 should be detached for use as the burial-transit	/Med	IF FEMALE:	23c. If yes, outcome of	of prednancy	,								
Bo	atten for us	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at t	2 ☐ Fetal de	ath 3	Ectopic preg					2	23d. Date of delive Month	ry Day Year
0	that the de ad by the detached	hysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown				,,						
Ö,	es that igned t be det	by P	Part II. Other significent conditions of			ig in the u	nderlying cau	se given	in Part I.		23e. Did to	bacco u	se contribute to th	e cause of death?
ecords,	n require been sign	0	421-410 Screwa	CC CAUX	CUAS	CUL	FUL I	الككر الك	少年		101	es 2	No 3 ☐ Prob	ably 4 □Unknown
ecc	e law re has be je 2 sho	Complete	HYPENTENKON	7							24a. Was	SV	prior to con	osy findings available inpletion of cause of
E B		Con	ANCHIA								perfo	rmed? 2. No	death?	2 🗆 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				0.1			(Check only o			
of	문 등 등	7. To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Injury	/ 28	Outpatier  b. Time of		, Injury at	4 🔲 Nurs		ne 5 🗌 Resid		Other (Specify	')
lon	Attanding Ph r death. sctor: After th by the funeral	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	М	Work?	s 2 🗆 N			,		
Division	or Attandi after death. Diractor: A in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home	, farm, str	eet, factory, o	office		2	8f. Location (S City or Tox	Street and	d Number or Rura	Route Number,
	itel or A	Cer		Downling, order	(0,000.1))					- 1	J., G. 7 J.	,, otato,		
	To the Hospitel or within 24 hours after To tha Funaral Dirticompletely filled in I	edical	(Check only 2 Medicel Exen	ysicien: To the best of the basis of	examination	dge, death and/or in	occurred at vestigation, in	the time, my opin	date and ion, death	place, a occurre	nd due to the old at the time,	cause(s) date and	and manner as sta place, and due to	ated. the cause(s)
	thin 2 tha ortha	Med	one) 29b. Signature and title of certifier	and manner stat	ed.		29c. L	icense n	umber			29d. Date	e signed (Month, L	Day, Yearl
	£ ≯ ∓ 8		MOT		A					15			-	. ,
	K		30. Name and address of person who	completed cause of de	ath (Item 23	a) (Type.	Print)	, ,	- 1			XI (	EN JEL	4/2007
	.1		P. WISOTSKYM	.0. 1207	O DL	0 4	NE C	807	80	W	HOORE	, de	1d. 2	2,2004 060z
	Sta		31. Date filed (Month, Day Year) 9	2004 32. Revistra	r's Signature	k	land.				,			
	Regist	ar			1		Market .							

			For State Registrar	State of Mai	- ,	artment of h rtificate of		, .	ene . N2 0 1 4	28515
	-	₹;	Decedent's Name (First, Middle, Last	it)		Timouto or		2, Date of Death	ING O O S	3. Time of Death
	Physici	an		,	<b>D</b> 1			Month	Day Year	D M
	/Medic Examir		Thomas W 3	11iam a street and number)	Bahner	4b. City, Town, o	or Location of Death	Sept. 7	4c. County of De	1:10 P M
E			902 Homberg 5. Social Security Number 6. S	Avenue		Esse			Balţim	
	. Funeral Director			ex M 2□F 58	(In yrs. last birthday) Yrs.	Months Days		8. Date of Birth (Month, Day, Y	<sup>(ear)</sup> 4,1946	rthplace (State or Foreign Sountry) Maryland
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	nation				10d Inside Obs. Lines
	show	5			•	, oation				10d. Inside City Limits 1 ☐ Yes 2 🌣 No
	28a-1	ecte	Md. Baltir	liore	Essex	10f. Zip Code		10-	Cities of latters C	
	E or	급	106. Street and Italicol			Tot. Zip Code		109	g. Citizen of What C	outiny?
	eath	eral	902 Homberg	Avenue 12. Was Decedent Ev	er in U.S. 13		21221 Hispanic Origin? (S)	necify Yes or No-	U.S.A. 14. Race - Am	lerican Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or Items 23c or 28a-1 show any injury or other traumatic event, the Modical Evertime trained by incilling and once.	by Funeral Director	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 AYes 2 □ No If Yes, Give Year or Dates: A		If Yes, specify Cub 1 ☐ Yes 2 ☐ <b>X</b> o	an, Mexican, Puerti	Rican, etc.)	Black, Wh	
Ö	hour tural	edt	15. Decedent's Ed			dent's Usual Occup	nation	16	b. Kind of Busines	
21215-0036	in 72	Completed	(Specify only highest gra	de completed)	(Give	kind of work done DO NOT use retire	during most of work	king	o. King of Dusines.	willoustry
12	i within iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		gineer		U.	.S. Gove	ernment
	should be filed within and Mental Hygiene.  s marked other than " umatic event, I've Man	Be C	17. Father's Name (First, Middle, Last)		,	<u>, <del>-</del></u>	18. Mother's Nam	ne (First, Middle, Ma	iden Sumame)	
Maryland	lid be lental ked ic ev	To B	Joseph F.	Bahner			Anna	М. Не	ergert	
ary	2 should and Men Is marke	-	19a. Informant's Name/Relationship (		19b. Maili	ng Address (Street	and Number or Ru	ral Route Number, C	City or Town, State,	Zip Code)
	1 and 2 Health a tem 27 ls		John S. Richar	dson	20	7 Kenna	rd Ave.	Edgewoo	d, Mary	land 21040
Baltimore,	es 1 a of Hea fitem r othe		20a. Method of Disposition		20b. Place of Dispo			Date 20	c. Location - City o	
E	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐  1 4 ☐ Donation 5 ☐ Other (Specify			vn Cemet			altimore	e, Maryland
alti	permit. Pages Department of Important: If i any injury or once.		21. Signature Funeral Service Licen	\$88	2	2. Name and Addre	ss of Facility			
ä	Depar Impol		Messec 7	mayeren	E B	iozazias	ski Fune Eastern	ral Home Avenue	e PA Essex	, MD 21221
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused the caused the cause on each line	ne death. Do not en	er the mode of dyli	ng, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
	Pnysician	K V	Immediate Cause (Final disease or condition resulting in death)	a. Houte	- myoca	rdial 1	mench	402		Onsor and Dough
	/Medical Examiner		Tosuming in dodain,	Due to (or as a	conseque ce of):	1 1	0	ภ	0	
		<u>_</u>	Sequentially list conditions,	b. Pue to (or as a	consequence of):	condic	resemble	1 disea	sil.	
	ted nsit	nju	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	240.00 (0. 40.4					*	
^	icate be executed physician and the burial-transit	Examiner	resulting in death) Last	c. Due to (or as a	consequence of):					
68760,	siciar b buri	ale	l	d						
89		edical		d.						
Вох	The law requires that the death certificate has been signed by the attending plates as Should be detached for use as I	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of de	alivery
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at ti		JEctopic pregnancy Other (specify)	y 		Month	Day Year
P.0	t the by th	hys	9 □ Unknown	9□Unknown						
	res that the de signed by the a be detached f	by Physician/M	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	cco use contribute t	o the cause of death?
Records,	w require been sig should b	ed t	Grogenous ob	eachy				1 ☐ Yes	2 □ No 3 □ P	robably 4 Jinknown
00	law re as bee 2 sho	ojet	Ü					24a. Was an	24b. Were a	utopsy findings available
Re	ician: The lav certificate has rector, page 2	Completed						autopsy performe 1 ☐ Yes 2 ☐	d? death?	completion of cause of
Vital	an: tiffica tor, p	BeC	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 ☐ th (Check only one)	<b>V</b> (40	2 2 140
<u> </u>	Physician: this certific ral director,	To B	examiner? 1 XYes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Oth		ome 5 XResidenc	e 6 □Other (Spe	acify)
of			27. Manner of Death	28a. Date of Injury (Month, Day)	28b. Time o			28d. Describe how		,
ion	Attendin death. ctor: Aft y the fun	atio	1 Natural 5 Pending 2 Accident investigation		rear) Injury		Yes 2 □ No			
Division	or Attending Ifter death. Director: After in by the fune	iffe	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, farm, str	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or R	ural Route Number,
Ö	tal or s afte al Dir	Certification;		ounding, oto.	(Speeny)			0.17 07 701111, 2	71410/	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exam	ysicien: To the best of niner: On the basis of e	xamination and/or in	n occurred at the til vestigation, in my o	me, date and place, ppinion, death occur	and due to the caus red at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	ithin 2 the mple	Med	one)  29b. Signature and title of certifier	and manner state	u.	29c. Licens	se number	294	. Date signed (Mon	th. Dav. Year)
	Y 3 1 8 1		J. Crossen C	Anna	MA		7632	C _	00 8	2001
	, *X,			completed cause of de-	th (Itam 22a) (Tiv==		1000	25	1-4.0	~~~ 7
	10.		- 50	vin, Mid.	2112 Dun		IVE BA	no mb	2122	
P	Sta Registr		SFP 0 9 2004	32. Registrar	s Signature	als!				

				State of Maryland /					•	· ·
			1 - For State Registrar			tificate of L			g. No. 0 0	28516
	Physici	an	Decedent's Name (First, Middle, Last	st)				2. Date of Death		3. Time of Death
	/Media	al	EVELYN L. BEAM  4a. Facility Name (If not institution, give	etraet and number		4b. City, Town, or	Langtion of Dooth	BERTEM	4c. County of	
	Examin		MORTH ARUND			Citer	1		Agun	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last bi	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		Birthplace (State or Foreign Country)
Į,	Director		243-14-0950 Usual Residence of Decedent	□ M XXF 83	Yrs.	Months	Tiours Ivini.	8/22/19	21 5	SOUTH CAROLINA
	land ow		10a. State 10b. County	10c. City, Tov	wn or Loc	cation				10d. Inside City Limits
	a-f sh	tor	MD ANNE	ARUNDEL GI	LEN	BURNIE				1 ☐ Yes 2 🛣 🛣 🕏
	with the	Funeral Director	10e. Street and Number 7466 FURNACE BRA	NCU DOAD		10f. Zip Code 2106	: n	10	g. Citizen of Wh	at Country?
	leath y	erai	11. Marital Status	12. Was Decedent Ever in U.S.	13. V	1/4		ecify Yes or No-		American Indian,
980	be filed within 72 hours after death with the Maryland ttal Hygiene. od other then "natural", or liems 23e or 28e-1 show event, the Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Warried	Armed Forces? 1 ∐Yes XXX No If Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cubai ☐ Yes XX No		Rican, etc.)		White, etc. WHITE
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		a. Deced	ent's Usual Occupa	ition uring most of work	sing 1	6b. Kind of Busin	ness/Industry
121	filed within Hygiene. ther then "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done d DO NOT use retired) EMAKER			OWN HON	AT.
<b>d</b> 2	filed Hygie other ent, the		12 17. Father's Name (First, Middle, Last)		11011		18. Mother's Nam	e (First, Middle, M		115
'lan	ould be Mental arked o	To Be	BENJAMIN E. OUTL	AW			CARRIE	B. WHIT	LEY	
Maryland 21215-0036	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (** DANIEL E. BEAM			g Address (Street a				
Baltimore,	S to I		20a. Method of Disposition  1XX Gurial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	DE LINE		sition (Name of patory or other place EN MEM。 I		100		ty or Town, State
Balti	permit. Pag Department Important: I any injury o		21. Signar O Funeral Service Ace	FINK #M01148		Name and Addres				
			23a. Part L Enter the disease or com shock or heart failure. List-only	plications that caused the death. Do one cause on each line.	not ente	er the mode of dying	, such as cardiac	or respiratory arres	st,	Approximate Interval Between
>	Physician		Immediate Cause (Final disease or condition resulting in death)	a DISSECTING	Ao	RTIC	ANEU	RYSM		Onset and Death
	/Medical Examiner			Due to (or as a consequence	of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence		,				
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	· HEURAL	12	FFUSIC	Mc			
,092	te be executed ysician and ie burial-transit		resulting in death) Last	Due to (or as a consequence	of):	LOIVE F	20 0000	1174 N		
687	# % B	edicai		dufferic OB	STE	Laire 1	EILINOH.	4-1-1	ハンドルシュ	
.O. Box (	The law requires that the death certificat the bas been signed by the attending phy agge 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			23d. Date of Month	
Records, P.	uires that t signed by Id be detac	þ	Part II. Other significant conditions o	ontributing to death but not resulting	in the un	derlying cause give	n in Part I.			ite to the cause of death?
000	aw requir s been si 2 should I	Completed						24a. Wasan	24b. Wei	re autopsy findings available
l Re	The lay	mo						autopsy performe	ed? dea	r to completion of cause of th?  Yes 2 3 No
Vital	ician: T certificat rector, p	Be C	25. Was case referred to medical examiner?					h (Check only one)		
of V	S = 5	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 patient 2 ER/O			4   Nursing nu	me 5 Residen		(Specify)
no		tion	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Time of Injury	28c. Injury Work	at ? ′es 2 □ No	28d. Describe how	r injury occurred	
Division	Hospital or Attending 14 hours after death. Funeral Director: Afte tely filled in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		arm, stre			28f. Location (Stre City or Town,		or Rural Route Number,
	To the Hospital or J within 24 hours after To the Funeral Dire completely filled in b	edical Co	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my knowledg niner: On the basis of examination ar and manner stated.	e, death	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the cau red at the time, dat	se(s) and manne o and place, and	er as stated. I due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c, License				Month, Day, Year)
	./		150/159	n	10	DZ	5149	Se	Framb	ER-5.2004.
	h		30. Name and address of person who	D		Print)	06 7	10 8	2.12.11	ER. 5. 2004.
		10	31. Date filed (Month, Day, Year)	32. Registrar's Signature	pisc	11 200	væ U	CEN	MENIE	
	Sta Registi		SED 0 9 200		da	all a				

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ORIGINAL

Dhycinian	4.5	State Registrar	Eint Mar				rtificate					giene Reg. No. 0	04 28	51
Physician /Medical Examiner		ALI	First, Middle, Las  CE  ot institution, give	t) street and numbe	BU.	54	4b. City,	Town, or	Location	of Death	Month SEPTEM	ber 4,2	Year	ime of Deat
Examine				TED LIVIN		ER	НУАТ						ICE GEORG	æ
uneral irector	5. So	cial Security Num 11–66–33	nber 6. Se		Age (In yrs. Ias 62				If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 11/28/	th	9. Birthplace (	
*	Usua 10a.	Residence of De State 1:	ecedent 0b. County		10c. City, 7	Town or L	ocation						10d. In:	side City Lis
f sho		TN	SHELBY			ЕМРН								KXes 2 □
r 28a	10e.	Street and Number	er				10f. Zip	Code				10g. Citizen of	What Country?	
23a c		319 DIXI	LE ROAD						38109			US	SA	
tringing and marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Exeminer must be notified at To Be Completed by Funeral Director	3	farital Status  Never Married  Widowed 4		12. Was Deceder Armed Force 1 ☐ Yes 2 2 If Yes, Give Year or Dates			Was Deced If Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	Speci	ice - American Inc ack, White, etc. ify: BLAC	
natu dece		15 (Specify	5. Decedent's Ed onfy highest grad	ucation de completed)		16a. Dece (Give	edent's Usua e kind of wor DO NOT us	l Occupa k done d	ation furing mos	t of worki	ing	16b. Kind of 8	Business/Industry	
t, the Medical E	Ele	mentary/Second	ary (0-12)	College (1-4o	or 5+)		DO NOT US		)			OV	IN HOME	
natic event, it	17. F	ather's Name (Fin	March 1		. 200-201-2						e (First, Middle,	, Maiden Suma LLD	me)	
ther trauma	19a.		e/Relationship (7)	ype, Print) (DAI DDARD	UG.)						E, MD 2		, State, Zip Code	)
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/sician ledical aminer	Imm	Part1. Enter the shock, or heart for ediate Cause (Fir ase or condition lting in death)	aifure. List only o	a. ATHO	tine. ERUS C							rrest, LASE		oximate val Betwee t and Dea
<u> </u>	Seni		_		as a consequer	nce of):								
ysician and e burial-transit cal Examine	resul	e. Enter Underly e. Enter Underly e. (Disease or injuitated events ting in death) Las		c	as a consequer	nce of):								
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gned by the attending physicis be detached for use as the but detached for use as the but by Physician/Medical	IF FE 23b.	EMALE: Was decedent print the past 12 mc 1 □ Yes 2 ⊠N 9 □ Unknown I, Other significa	regnant onths?	Due to (or a  Due to (or a  d.  23c. If yes, outcom 1 Live birth 4 Pregnant	as a consequer as a consequer ne of pregnanc 2  Fetal de at time of deat	nce of:  nce of):  ry eath 3[ th 5[	⊒Ectopic pre ⊒ Other (spe underlying ca	egnancy ecify)	n in Part I.		23e. Did to	23d. Da M	ate of delivery	se of death
e has been signed by the attending physicia age 2 should be detached for use as the bur ompleted by Physician/Medical	IF FE 23b.	EMALE: Was decedent print the past 12 mg 1	regnant onths?	Due to (or a Due to (or a d	as a consequer as a consequer ne of pregnanc 2  Fetal de at time of deat	nce of:  nce of):  ry eath 3[ th 5[	⊒Ectopic pre ⊒ Other (spe underlying ca	egnancy ecify)	n in Part I.		23e. Did to 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	23d. Da Mi  Dibacco use con  res 2 \sum No  an 24b.  ssy  mad2	ate of delivery onth Day stribute to the caus 3 Probably Were autopsy fin prior to completic death?	se of death  4 Dunkn  dings availan of cause
ifficate has been signed by the attending physicia or, page 2 should be detached for use as the bur e Completed by Physician/Medical	IF FE 23b.	EMALE: Was decedent print the past 12 mc 1 Yes 2 May 9 Unknown 1. Other signification of the past 12 mc 1. Other signif	regnant onths? No ant conditions co	Due to (or a Due to (or a d	as a consequer as a consequer ne of pregnanc 2  Fetal de at time of deat	nce of:  nce of):  ry eath 3[ th 5[	⊒Ectopic pre ⊒ Other (spe underlying ca	egnancy ecify)	in in Part I.	16-2	23e. Did to	23d. Da Mi Dbacco use con Yes 2 \( \text{No}\) an 24b. say say 2 2 No	ate of delivery onth Day stribute to the cause 3 Probably  Were autopsy fin prior to completic	4 Dunkn dings avail on of cause
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 12:03.pm Brown September 06 2004 /Medical Patricia 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** St Agnes Hospital
5. Social Security Number 900 S. Caton Ave BAHIMORE, Md If Under 1 Year If Under 24 Hrs. 21229 **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Min. 1 ☐ M 2 🟋 F Yrs. 51 Director 249-96-6286 Usual Residence of Decedent SC 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 le marked other then "neturel", or items 23a or 28a-f show other traumatic event, the Nedical Exar brack traumatic event, the Nedical Exar brack traumatic event. Director 1X Yes 2 □ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 U.S.A. 306 North Monastery Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No þ 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. It and Mental Hygiene. 7 Ie marked other then "no Elementary/Secondary (0-12) College (1-4or 5+) Private Seamstress 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roosevelt Brown Janie Mae Dargon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) os 1 and 2 sof Health an item 27 le 306 North Monastery Ave. Baltimore Md 21229 Carlton Brown-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of I 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō permit. Page Department of Important: If eny injury or once. Metro Crematory Inc. 9/8/04 Baltimore, Md 21. Signature of Funeral Sepice Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the essease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Athers sclentic disease or condition resulting in death) 1eas /Medical Due to (or as a consequence of): **Examiner** Znd S/ZCO Due to (or as a consequence of): End Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy Vital 1 ☐ Yes 2 ☑ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ð this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred To the Hospitel or Attending Division 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRUGGS Uni 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 9 2004 Registrar

Beach

Physicia		1. Decedent's Name (First, Middle, Last)  Latanya Genise B	aTanya Genise	Brown			2. Date of De Month	Day Year	3. Time of Death
/Medic Examin		48. Facility Name (If not institution, give street 4351 Seidel Avenue			y, Town, o	Location of De	eath	ber 7, 2004 4c. County of Dea N/A	
uneral irector		5 Social Security Number 9 6. Sex 1 □ M	2 F 39 (In yrs. last bir		er 1 Year	If Under 24 F	In. 8. Date of Bin. (Month, Date of Bin. June	n <b>6/17/1965</b> Bir	thplace (State or Foreign ountry) MD
28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County N / A	10c. City, Tow Balti						10d. Inside City Limits
st by nuti	ai Director	10e. Street and Number 4351 Seidel Avenu	e	10f. Z	Zip Code	1206		10g. Citizen of What Co	
natural, or Items 23a or 28a-f ehov odcal Examinat roust be ruillied al	by Fur	- C If	/as Decedent Ever in U.S. med Forces? ∐Yes 2 ☑ No Yes, Give ear or Dates:		edent of H becify Cuba 2 No	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or No lerto Rican, etc.)	14. Race - Ame Black, Whit	te, etc.
If item 27 is marked other than "nature or other traumatic event, the M. Co.	Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)	ollege (1-40r 5+)	Decedent's Us (Give kind of w life. DO NOT aycare	vork done d use retired	during most of ( f)	working	Residen	·
irked othe	To Be C	17. Father's Name (First, Middle, Last) Franklin Lewis					Name (First, Middle ane Brow	, Maiden Sumame) VN	
n 27 Is ma ser traums		19a. Informant's Name/Relationship ( <i>Type, F</i> Derrick Henderson	43	51 Sei	del	Avenue		er, City or Town, State, .	
뒫		20a. Mathod of Disposition  1	val from State 20b. Place of cometer Arbut	d Disposition (N. ry, crematory or U.S. Mem			2004	Baltimore	, MD.
Importal any infu		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ns that caused the death. Do n					neral Serv ore, MD. 2	Approximate Interval Between
ohysicia the bur	dicai Exa	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (1,15,25) of 1 first that initiated events resulting in death) Last  d.	Due to (or as a consequence  Due to (or as a consequence  Due to (or as a consequence	of):					
by the attending pached for use as	Physician/Me	in the past 12 months?	yes, outcome of pregnancy  Live birth	3 Ectopic   5 Other (s				23d. Date of del Month	ivery Day Year
be d	þ	Part II. Other significant conditions contribut	ing to death but not resulting in	n the underlying	cause give	en in Part I.		obacco use contribute to Yes 2 □ No 3 □ Pr	the cause of death?
ate has	Completed							an 24b. Were au prior to death? 2 \( \triangle	topsy findings available completion of cause of 2 No
this di	ToB	2 Accident investigation	a. Date of Injury 28b. 1	firme of njury M	28c. Injury Work 1 🗀 Y	4 Nursing	28d. Describe I	dence 6 QOther (Spechow injury occurred  Street and Number or Ru	
Funer stely fill	edical Ce	(Check only 2 Medical Examiner: (	t: To the best of my knowledge on the basis of examination and and manner stated.	, death occurred/ d/or investigation	d at the timen, in my op	ie, date and pla pinion, death oc	ace, and due to the courred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the Fur	Σ	29b. Signature and title of certifier  Losse R Hell 30. Name and address of person who comple	where MD		9c. License	ocmE		29d. Date signed (Month September	

State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) - BKOWN Day Year **Physician** TIM 2004 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Secours Hospital BALTIMORE BALTIMORECIT If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1፟፟∭M 2□F Months Days Hours Min. Yrs. Director 231-12-6624 83 3-11-1921 VIRGINIA Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director BALTIMORE CATONSVILLE MD. the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 0 Items 23a 124 MELLOR AVE. 21228 USA Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Items 23. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: BLACK 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) -8--0-TRUCKIDRIVER TRUCKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JESSIE A. BROWN FANNIE RICKMAN ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM C. BROWN JR. (SON) 2233 LAMARK AVE. LAS VEGAS, NEVADA 89106 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. BALTIMORE NATIONAL 9-10-2004 BALTIMORE, MARYLAND 4 □ Donation 5 Other (Specify) neral Septice Licensee JONATIAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardio inscular chisekse VOSC Pnysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medicai Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed V8 that initiated events physician and resulting in death) Last Box 68760. for use as the guipt IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) been signed by the a should be detached f 1 Yes 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by V81 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MIC page 2 autopsy performed SZ No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Funeral Director: After th completely filled in by the funeral ate of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHUKWUEMEKA UFOMADUMD STREFT HTIVA CHUKWUEMEKA BALTIMORE, MD 31. Date filed (Month, Day, Year) 9 2004 32. Registrar's Signature State Registrar

Amend item #10b,10d, per fh, 6835, 9/9/04 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 5, 2004 Physician DAVID BLOOMBERG 10:05 PM Μ. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3011 FALLSTAFF ROAD #506-A BALTIMORE N/A If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 8. Date of Birth OCT.5, 1924 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F 79 Yrs 215-16-1397 MD Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Itams 23s or 28s-f ehow the Medical Examinar must be notified at N/A Yes 250 BALTIMORE BALTIMORE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3011 FALLSTAFF ROAD #506-A 21209 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, within 72 hours after 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ WHITE 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FOREMAN MEAT PACKING other 1 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked other any Injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BLOOMBERG LENA MILLER BERNARD EVA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3011 FALLSTAFF ROAD #506-A ESTELLE BLOOMBERG / WIFE BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \*4 ☐ Donation 5 ☐ Other (Specify) MOSES MONTEFIORE WOODMOOR 9/8/04 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Se once. Scot 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician aldiac resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be axecuted as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical usa a IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ģ in the past 12 months? Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No n signad by tt. 1 be તેલ 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed bean 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 ☐ Yes 2 ☐ No 2 X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ů 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 14 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М death 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide in by t 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide fillad Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 2 Medical E the 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 9/6/04 pleted cause of death (Item 23a) (Type, Print) 30. Name an ddr s of p Jules I. Scherr 31. Date filed (Month Day, Year, 32. Reg State 2004 Registrar

RY	BERZOSK	Υ .	For Amer State Registrar	nd Item1	per me	<u>Har</u> yl <u>an</u>	g <mark>d De</mark> pa Cer	rtment of H tificate of L	ealth a Death	and Me	ntal Hyg	iene 	28522
	Physicia		1. Decedent's Name	(First, Middle, L			BEI	RZOFSKY			Date of Deat Month Septemb	Day Yea	3. Time of Death
>	/Medic Examin		4a. Facility Name (I			nber)		4b. City, Town, or	Location o			4c. County of De	
					Hospita			Roseo	dale	Od Hro la	. (2:4)		imore
ı	Funeral Director		5. Social Security N 219-38-	4893	Sex 1 M 2 □ F	7. Age (In yrs. 62		Months Days	Hours	Min. (	Date of Birth (Month, Day, OCT.3,1	9. E 941	Birthplace (State or Foreign Country)  MD
	land		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	the Marylar 28e-f ehow	tor	MD	Ч	BALTIMORI	E				В	BALTIMO	RE	1 ☐ Yes 2 No
	or 28¢	Funeral Director	10e. Street and Nur		M. 15			10f. Zip Code	11000		1	0g. Citizen of What	
	eath w	eral	1300 SUM	IMII AVE	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	dent Ever in U	S 13 V		1228	gin? (Specif	ty Yes or No-		USA merican Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23e or 28e-1 show any injury or other treumetic event. The Medical Examiner result he realisted at once.	þ		ied 2 Married 4 Divorced	Armed Fo	rces? 2 💢 No re		Vas Decedent of H f Yes, specify Cuba I □ Yes 2🎇 No	n, Mexican	i, Puerto Rio	can, etc.)	Black, W	
5-0	72 hc	etec	(Spec	15. Decedent's sify onfy highest of			(Give	lent's Usual Occupa	during most	t of working		16b. Kind of Busine	ss/Industry
Maryland 21215-0036	d within giene. r then '	Completed	Elementary/Seco	ndary (0-12)	College (1	-4or 5+)	CARPE	NTER	9			CARPENTR	:Y
pue	be file ntal Hyg ad othe event.	Be	17. Father's Name	(First, Middle, La			DEDZO	FCVV			First, Middle, M	Maiden Sumame)	RUBIN
7	should nd Men marke umetic	P <sub>C</sub>	SAMUEL  19a. Informant's No	ame/Relationship	D.		BERZO			NETTE or Or Rural F	Route Number	City or Town, State	
	alth an 12 s		RONALD E			HER						UM, MD 21	
Baltimore,	ges 1 a of He If item or othe		20a. Method of Dis		☐Removal from		Place of Dispo cemetery, crem	sition (Name of natory or other place				20c. Location - City	
Ħ	it. Pag rtment rtant: njury o			5 Other (Spe	city)	ОНЕ		OM MEMOR]		9/8/2			STOWN, MD
Ba	permit. Departimporta any inji		MUD	well?	Tug	~						ON & BROS IKESVILLE	, MD 21208
					mplications that c ly one cause on e	aused the deat ach line.	h. Do not ent	er the mode of dyin	g, such as	cardiac or r	espiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause disease or condition resulting in death)	(Final on	a. Due to	Owky	menca of):	uplicati	15	bead	In	way	
1	Examiner		Sequentially list co	nultions.	b.								
I	bet nsit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nmediate arlying injury	Due to	or as a consec	juence of):						
ó	execu an and rial-tra		that initiated events resulting in death)	s Last	c. Due to (	(or as a consec	juence of):						
8760	cate be executed physician and the burial-transit	dical		•	d								
Box 6	n certifi anding   use as	Physiclan/Me	IF FEMALE: 23b. Was deceden			oirth 2 🗆 Feta	al déath 3□	Ectopic pregnancy				23d. Date of Month	delivery Day Year
P.O. P	that the deatl ed by the atte detached for	nysic	1 ☐ Yes 2 i 9 ☐ Unknown	□No	4∐Pregn 9□ Unkno	nant at time of c	leath 5L	Other (specify)					
s, P	es that igned b	by Pł	Part II. Other signi	ficant conditions	s contributing to de	eath but not res	sulting in the u	nderlying cause giv	en in Part I.	. /	_	A-1	e to the cause of death?
ord	w requires been sign should be										1   Ye		Probably 4 Unknown
Vital Records,	The law ate has b page 2 s	Completed		<del></del>							24a. Was a autops perform	y prior ned? death	autopsy findings available to completion of cause of 1?  'es 2 \sum No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case reference examiner?		Hospital:			Oth	er		Check only on		
	× 5 0	. To	27. Manner of Dea		28a. Date	of Injury	ER/Outpatier 28b. Time of	IL 3 DOA	4 LINU			ence 6 Other (S	pecify)
ion	Attending r death.	atlor	1 □Natural 2 Accident	5 Pending investigat	tion 9/5	704 Year)	1520	) M 1□		No S	aibert	and fell	in water
Division of	or Atterdenter de Directorin by the	ertification;	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	~~ 280 U lace	of Injury - At h ing, etc. (Speci	of arm, str	eet, factory, office		28	City or Town	reet and Number or n, State)	Rural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	O	29a. Certifier (Check only	1 Certifying	Physician: To the	best of my knoasis of examina	owledge, death	n occurred at the time vestigation, in my o	ne, date an	nd place, and	d due to the ca	ause(s) and manner ate and place, and d	as stated. 3 1320
	To the P within 24 To the F complete	Medical	29b. Signature inc	title of certifier	and man	ner stated.		29c. Licens				9d. Date signed (Me	
•			10	Jark	erw	)			C.M.E	₹.	S	eptember	06, 2004
	5		30. Name al Gado	ress of person wi	WE, 1	se of Grath (Ite	111	Penn Str	æt,	Balti	more,	Maryland	21201
	Sta Regist		31. Date filed (Moi	SEP 0	9 2004	Registrar's Sign	ature	book					
			/.										

1 - For State Registrar Decedent's Na **Physician** /Medical 4a. Facility Name Examiner Sinai 5. Social Securit **Funeral** 215-12 Director Usual Residence permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28a-1 show any injury or other traumatic event. The Micros Francia in in must be rivilled at once. 10a. State To Be Completed by Funeral Director MD 10e. Street and 603 M 11. Marital Statu Buker, Mark 1 Never M Baltimore, Maryland 21215-0036 3 Widowe (S Elementary/Se 17. Father's Nan CHARL 19a. Informant's ELAINE 20a. Method of 1 🂢 Burial 4 □ Donatio 21. Signatore of 6 23a. Part1. Ent shock, or Immediate Cau disease or cond resulting in dea Pnysician /Medical Examiner Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated everesulting in death Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, IF FEMALE: 23b. Was dece in the past 9 Unkno Part II. Other sig 25. Was case re examiner?

5	pe or Print in Black State of Maryland / D			_	_	ole.
For State Registrar		Certificate of		Reg	1 (60 L	11, 29522
Decedent's Name (First, Middle, Last)     MARK	IRVIN		BAKER	2. Date of Death Month Sept 2M		Year 2004 7:22 PM
4a. Facility Name (If not institution, give stress  Sina Hoop (La)  5. Social Security Number  215-12-9165  Usual Residence of Decedent	of Baltimor 7. Age (In yrs. last birt	re Balti		8. Date of Birth	4c. County (	9. Birthplace (State or Foreign Country)
10a. State 10b. County  MD BAL	TIMORE 10c. City, Town	or Location BALTIM	ORE			10d. Inside City Limits 1 ☐ Yes 2 📉 No
10e. Street and Number  603 MILFORD MILL F	ROAD	10f, Zip Code	21208	100	g. Citizen of W	/hat Country?
11. Marital Status 12.  1 □ Never Married 2 💢 Married 3 □ Widowed 4 □ Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cul	Specify:	ecify Yes or No- Rican, etc.)		- American Indian, k, White, etc. WHITE
15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	ompleted) College (1-4or 5+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retir RODUCTION M	e during most of work ed)	ing		siness/Industry
17. Father's Name (First, Middle, Last) CHARLES	В. В	\KER	18. Mother's Nam	e (First, Middle, Ma		SILBERSTEIN
19a. Informant's Name/Relationship (Type, ELAINE BAKER / WIFI 20a. Method of Disposition	Print) 19b.	Mailing Address (Stree	MILL ROAD	- BALTIM	IORE, M	
1 X Burial 2 ☐ Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)  21. Signatore of Funeral Service Licensee		Disposition (Name of y, crematory or other pl. ON CHIZUK 22. Name and Addi		/2004	BALT	IMORE, MD
1 Cabert MIC	_ 4	8900 REIS	TERSTOWN I	ROAD - PI	KESVIL	LE, MD 21208
23a. Part1. Enter the disease, or complica shock, or heart failub. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Unidentying Cause (Disease or injury that initiated events resulting in death) Last  d. d.	Due to (or as a consequence of Due to (or as a consequence).	a n: embol n: uelogen	ing, such as cardiac	or respiratory arres	100	Approximate Interval Between Onset and Death  2 weeks  2 weeks
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnan 5 □ Other (specify)	су		23d. Date Mon	a of delivery th Day Year
Part II. Other significent conditions contri	buting to death but not resulting in	the underlying cause g	iven in Part I.	23e. Did toba	_	ibute to the cause of death?  3 Probably 4 Unknown
				24a. Was an autopsy performe 1 \square Yes 2	ed? p	Vere autopsy findings available rior to completion of cause of eath?  ☐ Yes 2 No
TE Tes ZUNO		ime of hjury M 1 [	ther: 4 Nursing Houry at ork?	h (Check only one) me 5 ☐ Residen 28d. Describe how 28f. Location (Stre City or Town,	injury occurre	
	ian: To the best of my knowledge r: On the basis of examination and and manner stated.					
29b. Signature and title of certifier	MD	PA	se number	290	d. Date signed	(Month, Day, Year) M DET 5, 2004
30. Name and address of person who com  Cindy X4v HVX  31. Date filed (Month, Day, Year)  SEP 0 9	pleted cause of death (Item 23a) (  M	rype, Print)  Ori Hospi  Apple	tal of	Baltim	one, 240	W Belveder Ave, Beltin

5 State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrer	State of Ma	aryland / Depa <i>Ce</i>	artment of H			giene		28521
ľ	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea	th	Year	3. Time of Death
	Physici /Medio		Sandra Carol (					Septemb	er 6, 21	004	12:45P ™
	Examin	er	4a. Facility Name (If not institution, give s  1 Brigantine Cow			4b. City, Town, o		eath	4c. County	of Death timor	0
	Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Birth			
	Director		210 02 4007	M 2 K	51 Yrs.	Months Days	Hours A	July 1	7,1953 F	enns	ace (State or Foreign Try) Ylvania
	land Sw		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10	Od. Inside City Limits
	Mary -f sho	tor	Maryland Baltimor	10.		Baltin	norte.				1 ☐ Yes 2 ☐ No
	ith the	Olrec	10e. Street and Number		·	10f. Zip Code		1	l0g. Citizen of W	hat Count	ry?
	ath w	ral	1 Brigantine Cou				21236			S.A.	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Plygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show eny injury or other treumatic event, I'm Medical Evandariant matter rediffed at once.	/ Funeral Director	1 ☐ Never Married 2 🛱 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐XN If Yes, Give	10	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕱 No	lispanic Origin? an, Mexican, Pi Specify:	? (Specify Yes or No- uerto Rican, etc.)	Black	- America k, White, e	
8	hours ture!',	d by	3 Widowed 4 Divorced	Year or Dates:		•			Specify:		
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2	ad with	Completed		College (1-4or 5	So	cial Work	er		Child P	rotec	tive Sucs.
Baltimore, Maryland 21215-0036	ild be fill ental Hy ked oth ic even	To Be	17. Father's Name (First, Middle, Last)  John Smith				18. Mother's	Name (First, Middle, 1 tty Jo	Maiden Sumame NES	e)	
ary	2 should and Men is marke reumatic	_	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailii	ng Address (Street	and Number or	r Rural Route Number	; City or Town, S	State, Zip (	Code)
<u>√</u>	and 3 lealth m 27 her tr		Mr. Kevin Carpente	er (husba				Baltimore,			
Jore	Pages 1 nent of H nnt: If ite ury or ot		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ R	emoval from State	20b. Place of Dispo				20c. Location - (	-	
Ē	nit. Parame artme ortent injury		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>	98	vulaney 22	Valley Me 2. Name and Addre	m · L   9 / I	10/2004	1 umonuun	п <b>,</b> ма	ryland
ä	permit. Departr Importe eny inju		racas	1		9705 Bela	ir Rd.	Schimunek Baltimor	tuneral e. MD 2	Home 1236	S
	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	e cause on each lir	the death. Do not ent	er the mode of dyin	g, such as care	diac or respiratory arre			Approximate Interval Between Onset and Death
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	nted nosit	Examiner	Tany, leading to infinediate cause. Enter Underlying Cause (Disease or injury	P#9 to (or 98:	s our sequence of):						
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9 xo	eath certific attending p for use as	/Mec	IF FEMALE:	3c. If yes, outcome	of pregnancy						
m	death e atten d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No	1 ☐ Live birth 4 ☐ Pregnant at	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date Mont		y Day Year
P.O.	that the di ed by the detached	hys	9 Unknown	9∐ Unknown							
Records, I	se us eq	by	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	. /		cause of death?
900	ne law requir has been si ge 2 should	Completed						24a. Was ar		ere autops	sy findings available
		Com						autops perform	ned? de	eath?	pletion of cause of □ No
Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		Othe		Death Check onl one			
ō	iding Physicien: Ih. : After this certifica i funeral director,	7: To	1 ☐ Yes 2 XNo	28a. Date of Injur	y 28b. Time of	28c. Injury	/ at	g Home 5 X Reside			
lon	ttending death. stor: Afte	atlor	1 XNatural 5 ☐ Pending investigation	(Month, Day	Year) Injury	Work	<br Yes 2 □ No		,,		
Division of	l or Attencatter dealt Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ry - At home, farm, str	eet, factory, office		28f. Location (Str City or Town	reet and Number , State)	r or Rural I	Route Number,
	pltel ( ours al erel D		29a. Certifier 1X Certifying Phys	ician: To the best	f my knowledge de-th	occurred at the co	no date and it	and due ( - 1)			
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	edical	(Check only one)	er: On the basis of and manner sta	of my knowledge, death examination and/or inv ted.	estigation, in my op	ne, date and pla pinion, death or	ace, and due to the ca courred at the time, da	use(s) and mani ite and place, an	ner as stat id due to t	ed. he cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1	11	29c. License	number	29	d. Date signed	(Month, Da	ay, Year)
	1		▶ Moshe Upon O		VIV	DS	903	2 5	ptenter	7, 1	2001
	0		30 Name and address of person who cor	mpleted cause of de	Path (Item 23a) (Type,	Print) dwgy Str	et b	iltura, N	10 212	カー	
	Sta Registr	3.1	SEP 0 9 20	32. Registra	r's Signature	fort		l			

			For Stata Registrar	State of M	laryland / D	epartment Certificate			and Me		jiene		28525
	Dhusisi	0.0	1. Decedent's Name (First, Middle, La	ist)					1	2. Date of Dea Month		Year	3. Time of Death
	Physici /Medio		CARSON W. CLEO							EPTEMBI	ER 6,	2004	6:40 P.M
	Examir	er	4a. Facility Name (If not institution, git					Location o				inty of Death	
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	Director			1 X M 2 □ F		rs. Months	Days	Hours	Min.	(Month, Day )ct. 6,	Year)	Sout	h Carolina
	Maryland If show	tor	10a. State 10b. County Md. Harfor	d	10c. City, Town	or Location Fore	est l	Hill					10d. Inside City Limits 1 ☐ Yes 2 No
	or 288	lrec	10e. Street and Number			10f. Zip (	Code			1	0g. Citizen	of What Cou	ntry?
	23a	rai	105K Sunshine Co	urt			2105	50			United	l Stat	es
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, If a Modical Ext. direct statt by nutified at page.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces: 1 Yes 2 1 If Yes, Give Year or Dates:	?	13. Was Decede If Yes, speci		spanic Origin, Mexican Specify:	gin? (Spec , Puerto Ri	ify Yes or No- ican, etc.)	E	Race - Amen Black, White, cify: Wh	can Indian, etc. ite
Baltimore, Maryland 21215-0036	vithin 72 ho ne. han "natur e M. dical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+)	Decedent's Usual Give kind of work life. DO NOT use	k done d a retired)	ition uring most	of working	7	16b. Kind of	f Business/In	dustry
7	filed w Hygiel thar ti		12 years  17. Father's Name (First, Middle, Lasi	)	р	hotograp	· ·	18 Mother	r's Name /	First, Middle, I			
yland	Mental I Merked or aric eve	To Be	Carson W. Clegg					Ethe	1 Lou	ise Da	vis		
Mar	alth and 25 h		19a. Informant's Name/Relationship Lillian B. Cleg	* *	19b. 10	Mailing Address ( 5K Sunsh	(Street a	nd Number Cour	ror <i>R</i> umall <b>t,</b> Fo	Route Number Prest H	; City or Tov 111, N	vn, State, Zip 1D 210.	50 Code)
more,	ages 1 a ent of He nt: If item ry or othe	ě	20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		cemetery	Disposition (Name, crematory or other of the Control of the Contro	her place		Dat /9/20			in-City or To	
Balti	permit. I Departm Importal any injui		21. Signature of Funeral Service Lice	• •		22. Name and Schimu	Addres:	s of Facility Fune	ral H	lome of	Bel A	Air, I	nc.
			23a. Part1. Enter the disease, or com	plications that cause	d the death. Do no	610 W.	Ma of dying	Phai	1 Roa	d, Bel	Air,	Md. 2	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each l	ine.	1	D	1					Interval Between Onset and Death
	/Medical		resulting in death)	a. Due to (or as	a consequence	):		المريد					
	Examiner		Sequentially list conditions,	b. der	ruce	oral	n	the	lup	,			
	bed sit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of	·):							
	al-trar	Examiner	that initiated events resulting in death) Last	ci Due to (or as	a consequence of	):							
8760,	ficate be executed g physicien and is the burial-transit	dical	(	d									
9	ntifical	Medi	IF FEMALE:										
P.O. Box	The law requires that the death certific Ite has been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐Ectopic pre- 5 ☐ Other (spe-					1	Date of delive Month	ery Day Year
	ires that I signed by I be deta	ρ	Part II. Other significant conditions	contributing to death t	out not resulting in	the underlying car	use givei	n in Part I.			eacco use co		ne cause of death?
Ö	w require been si should t	etec	co-ance go	au )	- Cu								
Il Records,		Completed					-		-	24a. Was ar autops perform 1 Yes 2	red?	prior to condeath?	psy findings available mpletion of cause of
Vita	ician certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Other		1	Check only on			
Division of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	lon: To	1 Yes 2 No  27. Manner of Death Natural 5 Pending	28a. Date of Inju	ury 28b. Ti	ury	c. Injury Work	at ?	280	5 Reside			y)
Visio	I or Attence after death Director: I in by the i	Certification:	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined		jury - At home, farr tc. (Specily)	n, street, factory,		es 2□N		f. Location (Str City or Town		nber or Rura	l Route Number,
Ω	pital o		200 Contilion 19 Continue Di										
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	ledical	one)	nysician: To the best miner: On the basis of and manner st	of examination and	or investigation, i	n my opi	nion, death	place, and n occurred	at the time, da	use(s) and r ite and place	manner as st e, and due to	ated. the cause(s)
	Viith To I	Σ	29b. Signature and title of certifier				License		*			ned (Month,	
•	~		1 Winds V	)			13	2.75	)		De pr	7,7	2004
	10		30. Name and address of person who DR. DAVID DUN	N - 615 W	. MacPHAI		- BE	L AIR	, MD.	2101	4		
	Sta Registr	_	SEP 0 9 20	32 Registr	rar's Signature	book							

Cleares, John Hyloy 10,25am

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			State Registrar			Certificate of	Death	Reg.	NO A A I,	28526
	Physici: /Medic		1. Decedent's Name (First, Middle, John Whitney					2. Date of Death Month September	Day Year 4 2004	3. Time of Death 10:25 A <sup>M</sup>
>	Examin		4a. Facility Name (If not institution, g	ive street and number)		, ,	or Location of Death		4c. County of Deat	h
			Gilchrist Hospi			Baltimo			Baltimo	re
	Funeral Director		080-38-7726	Sex 7. Age 1⊠M 2□F	(In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Sept. 5, 1	ear) Co	hplace (State or Foreign nuntry) V YOCK
	anyland show	ı	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town					10d. Inside City Limits 1 ☑ Yes 2 ☒No
	r 28a-f	recto	Maryland Harfor	:d	Bel Ai	10f. Zip Code		10g.	Citizen of What Co	
	23a o	al D	905 Fitzpatrick	Drive		21014			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant, I've Mydical Examinating the mailing at ance.	by Funeral Director	11. Marital Status  1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	
21215-0036	in 72 hou n "nature	Completed	15. Decedent's (Specify only highest	grade completed)	(9	ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	during most of work	ing 16t	b. Kind of Business/	
212	d with giene. Ir tha	mo	Elementary/Secondary (0-12)	College (1-4or 5- 4		otician			Optical	
	ld ba file ental Hyg kad othe ic avant,	To Be C	17. Father's Name (First, Middle, La Irvwin Donald	cleaves			18. Mother's Nam Virgini	e (First, Middle, Maid a (unk)	den Sumame) Whitney	
Maryland	d 2 shou th and M t7 is mar trsumst		19a. Informant's Name/Relationship Mary J. Cleaves			Mailing Address (Street )5 Fitzpatr		al Route Number, Ci		
	es 1 an of Heal fitam 2 r othar		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation3		20b. Place of D	Disposition (Name of crematory or other pla			. Location - City or	
Baltimore,	it. Pages rtment of I rtant: If its njury or of	1	'4 □Donation 5 □Other (Spe	pify)	Hilltop	Service C			wson, Mar	
Ba	permi Depa Impo any ir			1.11			sbury Roa	McComas F d, Abingd	on, Maryl	me, P.A. and 21009
	Physician /Medical Examiner		23a. Partl/ Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	mplications that caused in the caused in the cause on each line a.  Building a.  Due to (or as a	9.	Sliding	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
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68760,	icate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	c	consequence of	:				
.O. Box 6	death cartif e attending ed for use a:	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of deli Month	very Day Year
۵	w requiras that the dispansion of the spaen signed by the should be detached	by	Part II. Other significant conditions	s contributing to death bu	t not resulting in t	he underlying cause giv	ven in Part I.	23e. Did tobacc		the cause of death?
of Vital Records,	The la ate has page 2	Completed						24a. Was an autopsy performed 1 Yes 2	prior to death?	topsy findings available completion of cause of
/ita	sician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	5				h (Check only one)		
on of \	ding Phys h. After this funeral dir	tlon; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigal	28a. Date of Injury (Month, Day	t 2 EP/Outp / 28b. Tin /Year) Inju	ne of 28c. Injury		me 5 Residence 28d. Describe how in		ity) Hospice
Division	i i i i e	Certification;	3 Suicide 6 Could no determine		ry - At home, farm (Specify)	n, street, factory, office		28f. Location (Street City or Town, St	t and Number or Ru tate)	ral Route Number,
	ha Hospital n 24 hours a ha Funaral Dietely fillad	edical (	29a. Certifier (Check only one)  Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner stat	examination and/	death occurred at the to or investigation, in my o	me, date and place, opinion, death occur	and due to the cause red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
•	To tha within 2 To tha complet	M	29b. Signature and title of certifier	lun		D S	8303		Date signed (Month	. , ,
	141		30. Name and address of person when the state of the stat	on completed cause of de	ath (Item 23a) (T	ype, Print)				narles Stree
	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 9 20		r's Signature	pool			Towson, A	4d • 21204

		_	For State	State of Ma		d / Depa	artmen	t of H	lealth	and M	lental Hy	giene		
			State RegiSAMEND ITEM #10  1. Decedent's Name (First, Middle, Last)		G83	5 Cei	rlificat	e or L	Death	1	2. Date of De	Reg. No.	004	2 9 5 2 7 7 3. Time of Death
	Physici	an	Donald	Card	rev						Septer	\ Day	y th Year	
	/Medio		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location	of Death	-		County of Dea	
			Stella Maris					nium		0411			Baltin	
	Funeral Director		214-26-3921	7. Age	75 (In yrs. 1	last birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da Nov 5	iy, <i>Year)</i> 1928	C	thplace (State or Foreign ountry) yland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside City Limits
	Mary a-f sh	호	Maryland Baltimor	e	Timo	onium								1 ☐ Yes 2 No
	ith the	Sire	10e. Street and Number				10f. Zip					•	en of What C	ountry?
	s 23e	rall		K-306		5 10		1209		.093		USA		
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "neturel", or items 23e or 28e-f show or other treumatic event, the Medical Examinar must be notified at or other treumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ X Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent 8 Armed Forces? 1 □ Yes 2 □ N If Yes, Give Year or Dates:	lo		was Deced If Yes, spec 1 \( \text{Yes}		n, Mexica Specify		ecify Yes or No Rican, etc.)		4. Race - Ame Black, Whi <i>Specify:</i>	
9-0	2 hou		15. Decedent's Edu	cation	J J L	16a, Deced	dent's Usua	al Occupa	ation			16b. Kind	d of Business	
21215-0036	permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "arry injury or other treumatic event, the Medians in injury or other treumatic event, the Medians.	Completed	(Specify only highest grade	completed) College (1-4or 5-	+)	Phys	kind of wo DO NOT us ican	rk done d se retired	during mo: ()	st of worki	ng	Me	dicine	
pq	al Hyg	BeC	17. Father's Name (First, Middle, Last)		11				18. Moth	er's Name	(First, Middle	Maiden S	'umame)	
Maryland	ould b Ments arkad	To 6	Wilton Snowden	Carter					Luc		Ben			
Mar	d 2 sh h and 7 Is m treum		19a. Informant's Name/Relationship (Ty								1 Route Numb 306 Ti			
ē, L	Healt Healt tem 2		Rosamond K. Carte 20a. Method of Disposition		20b. P	ZJZJ lace of Dispo emetery, cren		,	_		ate III		ation - City or	
ē	Pages ent of nt: If i		1 N Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	lemoval from State			natory or o alley			9/8/0	14	Timon	ium. M	aryland
Baltimore,	permit. Pages Department of h Important: If ite any injury or ot		21. Signature of Funeral Service Lice	90 //	//		2. Name an							rk Road
	89558		las de	/ag//	1								owson,	Md.21204
201			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused ne cause on each lin	the death	n. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
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.40	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	;										
14 6: 58760,	ficate be executed physician and s the burial-transit		resulting in dealiny East	Due to (or as a	a consequ	uence ot):								
b4 687	fficate g phys	edical		1										
. 2004 Box 6	death certific e attending p od for use as	Physiclan/Me	in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	]Ectopic pr ] Other (sp					23	d. Date of de Month	livery Day Year
4 0		hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown										
SEPTEMBER Records, P	es ogn be	by	Part II. Other significant conditions con	ntributing to death bu	it not resu	ulting in the u	nderlying c	ause give	en in Part	l.	23e. Did t			o the cause of death?
PTEM	> 0 20	letec							-		24a. Was			utopsy findings available
_	The lar ate has page 2	Completed									autor		prior to death?	completion of cause of
LD Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:				Othe	200		(Check only o			
DONALD on of Vi	Phys ir this aral di	To It	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	v	ER/Outpatien 28b. Time of		8c. Injury Work	4/A/N		ne 5 🗌 Resi 28d. Describe I			cify)
o io	nding ath. r: Afte e fune	atior	1ÆNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	М		<br Yes 2□	No				
CARTER, DC Division	To the Hospitel or Attending Phys within 24 hours atter death. To the Funerel Director: After this completely filled in by the funeral di	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ıry - At ho (Specify	ome, farm, str	eet, factory	, office	77	2	28f. Location (S City or Tox		Number or Ru	ural Route Number,
CAF	e Hospit 24 hours e Funere letely fille	Medical C	29a. Certifier 12 Certifying Physical (Check only one) 2 Medical Examination)	sician: To the best of ner: On the basis of and manner sta	examinat	wledge, death tion and/or inv	occurred vestigation	at the tim	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		11		290	License	number			29d. Date	signed (Mont	h, Day, Year)
			Freshe	Who	9 Ht		1	5	27	40		Sel	temp	en 7th 2004
	BYLVA		30. Name and address of person who concerns the second sec	M.D. 230	O DU	LANEY	VALLE		DAD	TIMO	VIUM, M	D 210	93	
	Sta Registr	- 7	31. Date filed (Month, Day, Year) 0 9	2004 <sup>32. Regista</sup>	r's Signa	ture	Spece	E)						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ам SEPTEMBER 6, 9:20 Cadden 2004 Edith Askew /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month. Day, Year) Jan. 28,1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days 1 ☐ M 2 🛛 F Yrs. Alabama 215-22-2883 87 **Director** Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Parkville Maryland Baltimore Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 8710 Road 21234 USA 23a Emae death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō. 1 ☐ Yes 2 No Specify: Completed by 3 XWidowed 4 Divorced White "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Martin Marietta 10 Secretary other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be intented to Health and Mental int: If item 27 Is marked o McPherson В. Alice German Askew Webster ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lance McPherson/Nephew Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 0 permit. Page Department of Important: If any injury or once. 9/9/04 Dulaney Valley Cem. Timonium, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundami Service Licenses 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc.Towson.Md.21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) SEPSIS /Medical Due to (or as a consequence of): Examiner URINARY TRACT INFECTION Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last sician and Due to (or as a consequence of): Box 68760. Physician/Medical the attending phy use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached P.0. signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown END STAGE RENAL DISEASE Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan page 2 rmea≀ 2X No certificate 1 Tyes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 1X Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 1 XNatural 5 Pending death. investigation 2 Accident the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitel 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi-9-6-04 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 7601 OSLER DRIVE. TOWSON, MARYLAND 21204 BOOK 131 .IM. 31. Date filed (Month, Day, Year) 32. Register's Signature State SFP 0 9 2004 Registrar

	5		30. Name and address of person where a supplemental	ompleted cause of death (Item 23a) (Type	1838 Green	e Tree 1	Rd 2/208
	To with con	M	29b. Signature and title of certifier	Mo	29c. License number D7756  D. Print)  1838 Green		17/04 (Month, Day, Year)
	To the Hospitel or within 24 hours after To the Funerel Dirt completely filled in it	edicai	(Check only 2 Medical Exemi	sician: To the best of my knowledge, dea per: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occu	urred at the time, date and pla	ace, and due to the cause(s)
Divis	To the Hospitel or Attent within 24 hours after deatl to the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street and N City or Town, State)	Number or Rural Route Number,
Division of \	ding After fune	ation: To	1  Yes 2 No f 27. Manper of Death 1 Watural 5 Pending 2 Accident investigation	dospital: 1   Inpatient   2   ER/Outpatie		Home 5 Aesidence 6 C 28d. Describe how injury o	
Vital	ysicien: The l is certificate ha director, page	Be	25. Was case referred to medical examiner?	dospital:	0.4	ath (Check only one)	1 Yes 2 No
Record	he law requie has been age 2 should	Completed	Ight	ntersun		autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Ś	w requires that been signed I should be det		Part II. Dther significant conditions co	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use	contribute to the cause of death?
P.O. Box	Physicien: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be delached for use a	by Physician/Me	23b. Was decedent pregrant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at time of death 5 9□Unknown	□Ectopic pregnancy □ Other (specify)		d. Date of delivery Month Day Year
ς 68760,	artificate be executed ing physician and e as the burial-transit	dicai	IF FEMALE:	d			
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):			
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	antionyopathy		Onset and Death
Ö	permi Depa Impo any ir		23a. Part1. Enter the disease, or complishock, or heart failure. List only of	igations that caused the death. Do not er	uck Towson Funera		Approximate
Baltimore,	permit. Pages Department of I Importent: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature 1 ☐ Ingral Sarvice Licens	Mt. Oliv	ret 9/10 22. Name and Address of Facility		as City, MO O York Road
	00 0		Danny Christofano  20a. Method of Disposition	20b. Place of Disp		nt Valley, MD Date 20c. Loca	tion - City or Town, State
aryl	2 should be and Mental Is marked ( eumatic ev	2	19a. Informant's Name/Relationship (T)	(pe, Print) 19b. Mail	ling Address (Street and Number or R		own, State, Zip Code)
and	uld be filed Aental Hygi rked other tic event, I	Be	17. Father's Name (First, Middle, Last) Daniel Fizelli		18. Mother's Na Carolyn	me (First, Middle, Maiden Su	ımame)
21218	l within 7 iene. r then "n	Completed	(Specify only highest grad	College (1-4or 5+)	e kind of work done during most of wo DO NOT use retired) tered Nurse	Nursi	ng
Maryland 21215-003	2 hours	ted by	3 🕱 Widowed 4 □ Divorced  15. Decedent's Edu	If Yes, Give Year or Dates: cation 16a. Dec	edent's Usual Occupation	16b. Kind	oecify: WILLE of Business/Industry
(0	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other then "netural", or items 23a or 28e-f show other treumatic event, the Modical Examinal must be notified at	Funeral Director	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	to Rican, etc.)	. Race - American Indian, Black, White, etc.
	h with th	ai Dire	9773 Groffs Mill [	Orive Apt. 309	10f. Zip Code 21117	USA	n of What Country?
	Se-f sh	ector	MD Baltimore	e Owings MI			1 □Yes 2 □No
	ow II		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	Funeral Director		5. Social Security Number 6. Sec 497-28-6932	7. Age (In yrs. last birthday 7. Age (In yrs. last birthday 7. Yrs.	// If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreign Missouri
×	Examin	er	4a. Facility Name (If not institution, give 9773 Groffs Mill E	Orive Apt. 309	4b. City, Town, or Location of Deat Owings Mills	Bal	timore
	Physicia /Medic	al	Carolyn M. Chris		Tu su z	September 6	2004 10:55 PM
	•		Registrar  1. Decedent's Name (First, Middle, Last,		ertificate of Death	Reg. No.	3. Time of Death
			for State		partment of Health and	,5	001 00000

Known As: Patricia A Crockett.

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		For State					lealth and M			0.540.4
		1 - State Registrar AMEND TTEM  1. Decedent's Name (First, Middle, Las		er fh	g835	rtificate of	Death	2. Date of Dea	Reg. No.	3. Time of Death
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/Med		4a. Facility Name (If not institution, give					r Location of Death	250, 5.05	4c. County of Dea	
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Funera		5. Social Security Number 6. Se	ex 7. Ag	ge (In yrs. la		If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Day	h 9. Bi	thplace (State or Foreign
Directo		217-64-7226	□м <b>ЖЖ</b>	48	Yrs.	Months Days	Hours Min.	11 28		MD
pu 👔 🖫	7	Usual Residence of Decedent  10a. State 10b. County		10c. City	Town or Lo	ocation				10d. Inside City Limits
Aaryla Fsho	5									1X Yes 2 □ No
the the 28a-	Directo	MD NA  10e. Street and Number		Ват	imor	10f. Zip Code			10g. Citizen of What C	ountry?
3e or	0	5419 Price Ave				21	215		U.S.A	
deatl	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	5. 13.	Was Decedent of H	dispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-		erican Indian,
after or Ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ If Yes, Give		-	1 ☐ Yes 2√∑ No	Specify:	modif, otc./	Specify:	10, 610.
urel',	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:						В	lack
ING 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or Iteme 23e or 28e-f show event, tre Medical Evantiner must be inclined at	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of working	ng	16b. Kind of Business Baltimore	
d 212 filed withi Hygiene. wher then	dmo	Elementary/Secondary (0-12) 12th grade	College (1-4or	5+)			e Presid	lent	Community	College
Maryland 21 nd 2 should be filed w Ith and Mental Hygier 27 Is marked other ti	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Name	(First, Middle,	Maiden Surname)	
	To B	Rev. Van Lee S	Sr.				Ruth Ell	a Lew	is	
ore, Maryla s 1 and 2 should lot Health and Men itsm 27 Is marke other traumatic		19a. Informant's Name/Relationship (7	Type, Print) Sis	ter	19b. Maili	ng Address (Street	and Number or Rura	l Route Numbe	er, City or Town, State,	Zip Code)
Te, N 1 and 1 Health Ism 27		Cheryl Bradley	-Goldsbo	rough	241	6 Orlea	ns Stree		ltimore	
		20a. Method of Disposition 1 Disposition 2 Cremation 3 C		1200. Pla	CO OF UISDO	osition (Name of matory or other pla	- 0	ate	RANDALLS	
Baltimore,  Department of Hea  mportent: If itsm: may injury or other		`4 Donation 5 □ Other (Specify	v)	Arl	outus	: Memori	al Park	9/11/	04 Arbutu	s, Md
Baltimo permit. Pag Department Importent: I any injury o		21. Signatule of Funeral Service Licen	A LINE	1H	Ma	2. Name and Ad re	West	Dolti:	more Md	21215
		3a. P rt1. Enter the disease, or comphock, or heart failure. List only	plications that cause	the death.					more, Md	Approximate
		hock, or heart failure. List only	one cause on 4331	1			3,	F,		Interval Between Onset and Death
Physiciar /Medica	_	di ease or condition sulting in death)	a Due to (or as	a consequ	ence of):					
Examine			#17	POXE	niA					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ence of):					
acuted and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C							
60, be executed ician and burial-transit		leading in dealing East	Due to (or as	s a consequ	ence or):					
	Physician/Medical		d							
Geath certificate e attending phys d for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnar	ncy				23d. Date of de	livery
death a atter	clar	in the past 12 months?	1□Live birth 4□Pregnant a			□Ectopic pregnanc □ Other (specify) _	у		Month	Day Year
P.O.	hys	9 Unknown	9□Unknown							
	by P	Part II. Other significant conditions of	contributing to death t	but not resu	Iting in the u	inderlying cause give	ven in Part I.		obacco use contribute t	•
w require	ted	1751 HMM, CO	26 ESTIVE	1184	21 3	faimit		1 🗆 \	Yes 2□No 31 P	robably 4 Unknown
Vital Records, iiclen: The law requires t certificate has been signe rector, page 2 should be	Completed	Kistary 07 M	MOCARDIA	125	ARCT	·		24a. Was autop	an 24b. Were a prior to	utopsy findings available completion of cause of
	Con								rmed? death? 2 No 1 Ye	s 2 No
of Vital Rec hysiclen: The law his certificate has b I director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:	./	,	_ Ott	26. Place of Death			
Of Phys r this ral dil	다.	1 Yes 2 No	28a. Date of Inj (Month, Da		ER/Outpatie				dence 6 Other (Spenow injury occurred	ecify)
On Ith.	tlor	1 □Natural 5 □Pending 2 □ Accident investigation		ay Year)	Injury		rk? ]Yes 2□No			
Division of lor Attending Phy: after death. Director: After this in by the funeral di	Certification;	3 Suicide 6 Could not be determined	286. Place of in	njury - At hor	me, farm, st	reet, factory, office	2	28f. Location (S City or Tox	Street and Number or F	lural Route Number,
Div tel or A s after el Dire	Cert	4 Tiomicide	building, e	nc. (Specify	/			Ony 01 700	w, otato	
Division ( Hospitel or Attending I 44 hours after death. Funerel Director; After tely filled in by the funer	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medicel Exar	nysician: To the best	t of my knov of examinati	vledge, deat	th occurred at the ti	me, date and place, a	and due to the	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,	Med	one) 29b. Signature and title of certifier	and manner s	tated.		29c. Licens	se number		29d. Date signed (Mor	th Day Year)
To To		250. Signature and the of Certified				3			9-4.04	,
1		30. Name and address of person who	completed cause of	death (Item	23a) (Tuno		61529		1-4 07	
9	P. C.	MARK GOVES		Sim	. 11	opiM				
. S	tate	31. Date filed (Month, Day, Year)		trar's Signat		1				
Regis	strar	SEP 0 9 2004	Bere		0 1	aparks				

Physicia		Decedent's Name (First, Middle,	Last)							2. Date of D Month	Day		ear	3. Time of De	eath
/Medic		HARRIEH	Dans							Septe	mber	2, 20	004	0406A	. N
Examin		4a. Fecility Name (If not institution,		)	1	-		Location	of Death		4c.	County of	Death		
		841 E. 30th St			5 0 d d d d d d		timo:	re If Under	24 Hrs	0 Det - 1 D		Na		- (0)	
uneral rector		5. Social Security Number  215 86 3343  Usual Residence of Decedent	5. Sex 1 □ M 2	ge (In yrs. last b	Yrs.	Months		Hours	Min.	8. Date of B (Month, D	ay, Year)	969	County	ce (State or F	·oreig
show		10a. State 10b. County	1	10c. City, To									10	d. Inside City	
tams 23a or 28a-f shover must be notified at	Funeral Director	MD	V/a	DA	Himo									1,⊠Yes 2	
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ns 23	eral	1009 ARGY/E	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	<u> </u>		ispanic Or	igin? (Spe	ecify Yes or N Rican, etc.)	10-	14. Race -	America		
٠	by Fur	1 ☑ Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? d 1 ☐ Yes 2 [4] If Yes, Give Year or Dates:	? No		fYes, spe⊲ I□Yes		Specify:		Rican, etc.)	- 1	Black, Specify:	White, e	tc.	
"natural",	Completed	15. Decedent's (Specify only highest	Education grade completed)	16	Sa. Deced	lent's Usua kind of wo	al Occupa	ation	st of work	na	16b. Kii	nd of Busin	ness/Indu	istry	
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item 27 is marka othar traumatic	၉ .	19a. Informant's Name/Relationshi	p (Type, Print)	19	9b. Mailin	g Address	s (Street a			i Route Num		r Town, Sta	ate, Zip (	Code)	
27 ls r trau		HARRY Davis			15.5	ngy/8									
f item 27 r othar tr		20a. Method of Disposition		20b. Place	of Disnos	sition /Nar	me of	(a)	[	mons N	20c. Lo	cation - Cit	y or Tow	n, State	,
nt: If ry or		1 Burial 2 □ Cremation 3  1 □ Cremation 5 □ Other (Spe		MOLE	land	Oem	eten	/	9/9	104	BAH	MORE	Mna	1 lovel	
Important: If item any injury or otha once.	1	21. Signature of Funeral Service Li	censee		22.	. Name ar	nd Addres	s of Facili	ty 13 &	104 HS FUI	neral	Hem	e		
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DAVID DESROSIERS	For	State of Maryland / Department of Health and Mer	-

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			Registrar  1. Decedent's Name (First, Midd	dle, Last)			tineate of L	Jean	2	. Date of Deat		1	3. Time of Death
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	/Medic Examin		David  4a. Eacility Name (If not instituti	Micha on, give street and n		D€	srosiers 4b. City, Town, or	Location of	Death	OLI I.	4c. County of		0022 A
1	LAGITIII	CI	4a. Eacility Name (If not instituti 7605 ENERGY I	PARKWAY			CURTIS				ANNE A		EL
	Funeral		5. Social Security Number	6. Sex	7. Age (In yr	rs. last birthday)	If Under 1 Year	If Under 24	4 Hrs. 8	Date of Birth (Month, Day,	Voor) 9	Birthpl	ace (State or Foreign
	Director		019-46-9935	1 2 M 2 □ F	47	Yrs.	Months Days	Hours		Sept. 1		Count lass	ny) achusetts_
	B .		Usual Residence of Decedent		10- /	Oir T							
	anyla shov	-	10a. State 10b. Coun	·У	100.	City, Town or Lo	cation					10	od. Inside City Limits 1 ☐ Yes 2 🗷 No
	Ba-f	Director		e Arundel	Pa	asadena	T						
	with t	급	10e. Street and Number	ъ.			10f. Zip Code	0		10	g. Citizen of Wha		ry?
	ours after death with the Maryland ral', or liems 23a or 28a-f show Examiner must be notified at	Funeral	157 Cottage Gr		cedent Ever in	119 121	2112:		in? (Specif	Voc or No	U.S.		n Indian
		'n.	11. Marital Status  1 □ Never Married 2 ☑ Ma	Armed F	Forces?	0.5.	Was Decedent of Hi f Yes, specify Cuba	n, Mexican,	Puerto Ric	an, etc.)		White, e	
336	hours after lural', or Ite	by F	3 Widowed 4 Divorce	If Yes G	aive _		I ☐ Yes 2 <b>ℤ</b> No	Specify:			Specify:	Whi	+0
5-0036	72 hor	ted	15. Decede	ent's Education	4	16a. Deced	lent's Usual Occupa	ation		1	6b. Kind of Busir		
21.5	within 7 ene. than "n	Completed	(Specify only night Elementary/Secondary (0-12)	est grade completed	(1-4or 5+)	life.	kind of work done o OO NOT use retired,	luring most o )	of working				
2121	e filed within al Hygiene. I othar than " vent, Ina Me	Con	12	2		Mac	hinist				Gischel	L Ma	chine Co.
pu	al Hy a oth	Be (	17. Father's Name (First, Middle	, Last)				18. Mother	's Name (F	First, Middle, M	laiden Sumame)		
yla	2 should be and Mental la markad c aumatic eve	Jo	Ronald		Des	sr <u>osiers</u>			roth				yon
Maryland	2 sh and lam raum		19a. Informant's Name/Relation	nship (Type, Print)			g Address (Street a						
d)	s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene. item 27 Ia marked othar than "natural", other traumatic event, Ita Medical Eas		Bridget A. Des	rosiers (	Wife)	157 C	Cottage G	rove D	rive Dat				
Jor	if ite		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation		n State		sition (Name of natory or other place				0c. Location - Cit	,	•
Baltimore,	rt. Parturant		'4 □ Donation 5 □ Other		Ba		rematory		9/11/		altimore		aryland
Ba	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service	Z CII	***	Mo	Name and Addres	lyniak	Fun	eral Ho	me, P.A.	1	01100
			23a. Part. Enter the disease,	or complications that	caused the de	3,	204 Mounta	ain Ko	oad P	<u>asadena</u>	, Maryla	ana	ZIIZZ Approximate
	Diameter in		shock, or heart failure. Li	st only one cause on	each line.					, ,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Dua t	o (or as a cons	0/6 I	njurie	<u> </u>				_	·
	Examiner			Dus to	J (01 43 4 CO1131	equence or,							
	executed n and ial-transit	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due K	o (de as a echsi	aquanta ot).							
1		Examiner	that initiated events	C									
o,	e exe ian ar ırial-t	EX	resulting in death) Last	Due to	o (or as a conse	equence of):							
68760,	tificate be executed ig physician and as the burial-transit	edical		d									
	certific nding p use as		IF FEMALE:	322 16 1122 2									
Вох	death certifi e attending ed for use as	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of preg birth 2 ☐ Fe	etal death 3	Ectopic pregnancy			23d. Date of delivery  Month Day Ye.			·
0	0 0 D	Physician/M	1 ☐ Yes 2 X No 9 ☐ Unknown	9□ Unk	gnant at time of nown	rdeath 5L	Other (specify)						
0	requires that the de een signed by the a rould be detached t	Ph	Part II. Other significant condi	tions contributing to	death but not re	esulting in the ur	nderlying cause give	n in Part I.		23e. Did toba	acco use contribu	te to the	cause of death?
ds,	sign d be	d by	, and the second	, and the second			, , , , , , , , , , , , , , , , , , , ,			1 ☐ Yes	37		bly 4 ⊟Unknown
Sor	> d ts	Completed								24a. Was an	24h Wos	n auton	sy findings available
Re	e la has	ш								autopsy	prio	r to com	pletion of cause of
E	ilcian: Th certificate rector, pag	e Co	25. Was case referred to medic	sal .				00 Disease	4.04-70			Yes 2	No No
of Vital Records,		o Be	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatien	t 3 DOA Othe			heck only one		Canaiful	AT SCENE
o	g Phys er this eral di	Certification; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. D							d. Describe how injury occurred			
ion	Attending I r death. ector: After by the funer			ling stigation 9/7	104	8:10 /	M 1XY	U	subject caught in .				
Division	er de recto by th	tific	3 Suicide 6 Could 4 Homicide deter	d not be mined 28e. Place	home, farm, stri	eet, factory, office	28f	28f. Location (Street and Number or Rural Route Number, City or Town, State) 7605 Energy PKO					
O	rs after all or	Cer		M	lochen	e shop			A	rue Ari	under (0	. M	D PRW
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certify (Check only 2 Medice	ring Physicien: To the el Exeminer: On the	ne best of my ki basis of exami	nowledge, death	occurred at the tim	e, date and printed	place, and	due to the cau	use(s) and manne	r as sta	ted.
	the	Med	one)	and ma	nner stated.								
	Vail To COI	-	29b. Signature and title of certif	1/10000		1	29c. License			29	d. Date signed (N SEPT.		2004
			Lucae	Mulle	i m	2001-							
	SXIVA		30. Name and address of person	n who completed cau	IN A	ет 23a) (Туре, 111 <b>Pen</b> i	n Street,	Balti	imore	, Marvl	and 2120	)1	
	Sta	te	31. Date filed (Month, Day, Yea		Pigistrar's Sig	nature	_			,			
*	Registr		SEP 0	9 2004	ESPINE	K A	made)						

			1 - State Registrar	State of Ma per Ver	ryland / D	6970970 Certificat		ealth and Me Death	ental Hygi Re	ene g. Not O	00500		
	Physici		1. Decedent's Name (First, Middle, Last)	JoAnn	Dalci	in			2. Date of Death Month	Day Year 2004			
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City,		Location of Death		4c. County of De	ath		
			6205 FALLS ROA  5. Social Security Number 6. Sec		e (In yrs. last birt	hday) If Under	N/A 1 Year	If Under 24 Hrs.	B Date of Birth		IMORE		
L	Funeral Director			м ХЖЕ		rs. Months	Days	Hours Min.	B. Date of Birth (Month, Day, 06-16-1		rthplace (State or Foreign Country) LABAMA		
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits		
	Maryl	tor	MD. BALTIMO	RE			BALT	IMORE COL	YTNL		1 □ Yes 2 <b>)(</b> No		
	death with the Maryland ms 23e or 28e-f show rmust be notified at	Director	10e. Street and Number			10f. Zip		1000	10	g. Citizen of What C			
	eath w	Funeral	6205 FALLS ROA	D 12. Was Decedent I	Ever in U.S.	13 Was Decer		L209 panic Origin? (Spec	ify Yes or No-	U. S.			
5-0036	or the	by	1 Never Married 3 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 XX  If Yes, Give Year or Dates:		If Yes, spec	Cuban	Specify:	ican, etc.)	Black, Wh			
2-0	72 hc	eted	15. Decedent's Edu (Specify only highest grad		16a.	Decedent's Usua (Give kind of wo	rk done du	tion uring most of working	1	6b. Kind of Busines	s/Industry		
2121	e filed within al Hygiene. I other than ' vent, the Ma	Completed	Elementary/Secondary (0-12) 12 YEARS	College (1-4or 5	+>	life. DO NOT us OWN				CONSTRUCT	ION COMPANY		
	al Hyg d othe	BeC	17. Father's Name (First, Middle, Last)		0.00			111-1		ddle, Maiden Sumame)			
Maryland	2 should be and Mental is marked ceumatic ever	<sup>L</sup>	JOHN CLINTO  19a. Informant's Name/Relationship (Ty			Mailian Addans	(C4===4==	MARGAF		EED  City or Town, State,	7-0-1)		
	₽ € <b>~ ≥</b>			(HUSBAND)						LAND, 2120			
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial ※X☐ Cremation 3 ☐ F	emoval from State	20b. Place of cemeter	Disposition (Nan v, crematory or o	ne of ther place	) Da	te 2	0c. Location - City of	r Town, State		
tim	t. Pag rtment rtent: I njury o		4 □ Donation 5 □ Other (Specify)		HILLTO				-2004 T	OWSON, MD.			
Bal	Depa Impo any ir	, li	21. Signature of Funeral Service Licens				10 S W O	FUNERAL		C. TOWSO	YORK ROAD N.MD.21204		
	Priysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ie cause on each lir	astric	Can			respiratory arres	st,	Approximate Interval Between Onset and Death (6 VNcA M S		
1	Examiner		Construction line and distance	Due to (or as	a consequence o	r):							
in 188	sit s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury										
ά,	tate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last										
68760	icate be execu physician and s the burial-tra	edical		l									
	.≑		IF FEMALE:	3c. If yes, outcome	of pregnancy								
O. Box	death e atte d for	Physician/M	23b. Was decedent pregnant in the past 12 months?  1							23d. Date of de Month	Day Year		
ds, P	requires that the de een signed by the a rould be detached	by	Part II. Other significant conditions cor	itributing to death bi	ut not resulting in	the underlying ca	ause giver	n in Part I.			o the cause of death?		
Records,	e law has b	Completed							24a. Was an autopsy performe	prior to eath?			
of Vital	i <b>cien</b> ; Th certificate rector, pag	Be Co	25. Was case referred to medical examiner?					26. Place of Death (	1 ☐ Yes 2 €		s 2 No		
of V	Phys this al dii	P	1 ☐ Yes 2 ☐ No	lospital: 1 Inpatie	-		_	4   Nursing nome		ce 6 LeOther (Spe	acity) HUNGE		
on	ding After fune	tlon	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y 28b. T Year) In	jury M	8c. Injury : Work? 1 ☐ Y	at ? es 2 □ No	d. Describe how	vinjury occurred			
Division	ol or Attendi after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At home, far c. <i>(Specify)</i>	m, street, factory	, office	28	f. Location (Stre City or Town,	eet and Number or F State)	ural Route Number,		
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying Physical Examination	sician: To the best of ner: On the basis of and manner sta	examination and	death occurred for investigation,	at the time in my opi	e, date and place, an nion, death occurred	d due to the cau l at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)		
	To th within To th comp	M	29b. Signature and title of certifier				. License		290	d. Date signed (Mon			
•			1 Day Men	lentery	MOD.		051	260		reptember	3, 2004		
_			30. Name and address of person who co	4 mia	22. SUN	· Greene	St.	Ba Hunor	mo	2/201			
	<ul><li>Sta</li><li>Registr</li></ul>		31. Date filed (Month, Day, Year) SFP 0 9 2004	32. Registra	ar's Signature	and s							
			DEL A A FOOT	many.	- 17								

Physici /Media		Decedent's Name (First, Middle,      CLATRE LEE DA	Last)	AIRE	LEE	<b>DAVIS</b> C				2. Date of De		, 2004	3. Time of Death
Examir		4a. Fecility Name (If not institution, g	•	,		4b. City, To			of Death			NE ARU	
Funeral Director		219-12-3419	5. Sex 7. A	Age (In yrs. Ia <b>79</b>	st birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir 11/26/	1924	9. Birth	place (State or Forei Ř <b>ÝLAND</b>
ms 23a or 28a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD ANNE A	ARUNDEL		Town or Lo								10d. Inside City Limit
3a or 28	I Dire	10e. Street and Number 210 N. HAMMONDS	S FERRY ROA	AD		10f. Zip C	ode 2109	90			10g. Citizer	n of What Cou	ntry?
of Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28a-f show other traumetic event. The Modical Examined must be notified at	d by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Married	If Yes, Give Year or Dates	s? <b>X</b> No		If Yes, specify  1 ☐ Yes	y Cubar No	Specify:	gin? (Spe a, Puerto i	cify Yes or No Rican, etc.)		Race - Ameri Black, White pecify: WHI	etc.
giene. erthen "nati	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+	r 5+)	(Give life.	dent's Usual ( kind of work ( DO NOT use )	done di	uring mos	t of workii	ng	16b, Kind	of Business/Ir	dustry
th and Mental Hygiene. 7 Is markad other then "r traumetic event, the Med	To Be C	17. Father's Name (First, Middle, La MICHAEL DOOLEY						A	NNA	(First, Middle,	AN		
Health and tem 27 is m		19a. Informant's Name/Relationship TIM DOOLEY	o (Type, Print)							l Route Numbe ONSVILI			Code)
5 = 5		20a. Method of Disposition  1 XXurial 2 Cremation 3  4 Donation 5 Qther (Special Control of Control		e cer	metery, crei	osition (Name matory or othe HEDRAL	er place	_   _	□ /11/	ate 2004		ion - City or To	
Departmer Important any injury once.		21. Signature of Fig. ra	RY FINK #MO	01148		2. Name and A			L.T.	NK FUNE	CRAL H	OME, P.	
		shock, or heart failure. List on	ly one cause on each	ed the death. line.	Do not ent	er the mode o		, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
Medical xaminer	cal Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or its pury that initiated events resulting in death) Last	a	ed the death, line.  Cas a conseque as a conseque as a conseque	Pence of):	-	of dying	, such as		r respiratory ar	rest,		Approximate Interval Between Onset and Death
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tor: After this certificate has been signed by the attending physician and upper the funeral director, page 2 should be detached for use as the burial-transit upper the funeral director.	To Be Completed by Physiclan/Medical	Snock, or near failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Lisease or know that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 No 27. Manna of Death 1 Natural 5 Pending investigati 2 Accident investigati 3 Suicide 6 Could not	Due to (or a b. Due to (or a c. Due to (or a d.  23c, If yes, outcom 1	ine.  Cas as a conseque as a conseque as a conseque as a conseque but of pregnance 2 Fetal d at time of dea but not result but not result  conseque 2 Fetal d at time of dea	ence of):  ence of):	DEctopic pregri	nancy Other Injury a Work?	an in Part I.	of Death	23e. Did to 1	23d.  bacco use of ses 2 (1)  an 24  sy mad? 2 (2)  ence 6 □  ow injury oc	Month  contribute to the contr	ery Day Year  De cause of death?  The cause of death?  Day 4 Unknown  Day 6 Unknown  Day 7 Unknown  Day 7 Unknown  Day 8 Unknown  Day 9 Unkno
ifter death.  Director: After this certificate has been signed by the attending physician and upper properties of the timeral director, page 2 should be detached for use as the burial-transit upper properties.	Certification; To Be Completed by Physician/Medical	Snock, or neart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a b. Due to (or a c. Due to (or a d.  23c. If yes, outcom 1	ine.  Cas a consequence of pregnance 2 Fetal dat time of deal but not result tient 2 Efficient 2 Effic	ence of):  ence of):	DEctopic pregri	nancy Other Injury a Work?	26. Place 4 Nui at Nui	of Death rsing Horrison 2	23e. Did to  1 Yes  24a. Was a autop. perform 1 Yes  (Check only or less of the side of th	23d.  23d.  24es 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Month  contribute to the contr	Interval Between Onset and Death Onset and Death Is TRANS  Bry Day Year Day Year Day 4 Unknown Day findings available impletion of cause of 2 No  I Route Number,
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dev Year **Physician** 2004 1:45am September Ethel Draughon /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Baltimore 6900 Meadowlawn Road Birthplace (State or Foreign Country)
 N C If Under 1 Year 8. Date of Birth (Month, Dey, Year) 11 03 27 7. Age (In yrs. lest birthday) 5. Social Security Number **Funeral** Hours Devs Months 1 ☐ M 2 ☑ F Yrs. Director 76 240-44-9981 Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "naturel", or items 23a or 28a-f ehow the Medical Examiner must be notitled at 1√⊈ Yes 2 ☐ No Director Baltimore MD NA 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code Funeral U.S.A. 6900 Meadowlawn Road 21207 14. Race · American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2/C/No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify. ģ 3√Vidowed 4 □ Divorced Black Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Domestic Worker Private 11th grade na permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if Itam 27 ie marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Maretta Counal Crosby Munn 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6900 Meadowlawn Road, Baltimore, Md 21207 Deborah Dent-Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete t☐Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) King Memorial Park 9/7/04 Randallstown, Md 21. Signature of Funeral Service Licenses March F/H West w ree 4300 Wabash Ave, Baltimore, Md 21215 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Daath Physician /Medical Immediate Cause (Final Mos Multiple Myleoma disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner Mos Anemia To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completally filled in by the funeral director, page 2 should be datached for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Yrs Box 68760. Diabetes Mellitus Type II Physician/Medical Due to (or as e consequence of): Yrs <u>Severe Osteoporosis</u> P.O. | 23b. Did tobacco use contribute to the cause of deeth? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 2 No 3 Probably 4 Unknown 1 Yes Leukopenia, Parkinson Š Division of Vital Records, 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed Superventricular Tachycardia completion of cause of death? TLIYUE SKINO 1 ☐ Yes 2 No Malnotrition Be 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end clace, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifie (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of confiler D54749 09/03/2004 30. Name end eddress of person who completed cause of death (nem 23e) (Type, Print) Toll 801 House D-1, Frederick, Maryland 21701 Allen Reilly Md, 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

SEP 0 9 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death ecedent's Name (First, Middle, Last) Year **Physician** 10:49 AM September 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner BEHERAL rs. last birthday) 8. Date of Birth (Month, Day, Year) 7. Age (In If Under 24 Hrs. 5. Social Security Number 6. Sex If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 12M 20F 218-36-3359 Director Jsual Residence of Deceder 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a\_State 7 is markad other than "natural", or itams 23a or 28a-f show traumatic evant, the Meulcul Evanti ar must be notified at 1 **Y**es 2 □ No Funeral Director MUYE 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 13. Was Deceden If Yes, specify panic Origin? (Specify Yes or No-Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Blac 1 ☐ Yes 2 ☐ No Specify. þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education city only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. y/secondary (0-12) Baltimore, Maryland 2121 College (1-4or 5+) (First, Middle, Last, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health 20c. Location - City or Town, State Department of Important: If it any injury or o 8urial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee /auxul Poad 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one caus each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OHKHOWY Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner ed by the attending physician and detached for use as the burial-transit requires that the death certificate be executed Shuc SEVERE Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 0 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown icate has been sig , page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 🗆 No 1 Yes certificate Vital Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 0 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and use to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signatu

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ALFRED TOMLIN  19a. Informant's Name (First, Middle, Last)  ADONICA CROWDY / DAUGHTER 1758 GALLOWAY RD, BOLIVIA, NC 28422  20a. Method of Disposition  10b. Place of Disposition (Name of cemetery, crematory or other place)  ARBUTUS MEMORIAL PK 9/9/04 BALTIMORE,  21. Signature of Uneral Service Licensee  17. Fether's Name (First, Middle, Maiden Surmame)  18. Mother's Name (First, Middle, Maiden Surmame)  18. Mother's Name (First, Middle, Maiden Surmame)  19a. Informant's Name (First, Middle, Maiden Surmame)  19a. Informant's Name (First, Middle, Maiden Surmame)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Control of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)  ARBUTUS MEMORIAL PK 9/9/04 BALTIMORE,  21. Signature of Functions of Facility  4600 LIBERTY HGHTS AV, BALTIMORE	2.
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			Registrar     Decedent's Name (First, Middle, Last,	)				2. Date of De	Reg. No.	3. Time of Death
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	Funeral Director		210-20-033/	7. Age	(In yrs. last birthday Yrs.	) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	ay, Year)	Birthplace (State or Foreign Country)  Ralt. Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
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Division of	or Attending after death. Director: Aftel in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)		2 2 110	28f. Location (S City or Tox	Street and Number o vn, State)	or Rural Route Number,
_	To the Hospital or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	h occurred at the tim	e, date and place inion, death occu	, and due to the a	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	· · ·		29c. License			29d. Date signed (N	
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	3		30. Name and address of person who co		ath (Item 23a) (Type,	SALTO	1. M.	72113	3	SER 7, 2004
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FULGHAM - HARPER Month Year 823AM RUB SEPTEMBER 06, 2004 /Medical 4a. Fecility Name (ff not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL SECOURS BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Pay, 5. Social Security Number 7. Age (fn yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🟋 🛣 66 241-60-6192 Director 8/23/1938 SCOTLAND Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 7 is marked other then "naturel", or itams 23a or 28a-f ehow treumetic event, the Medical Examinar must be notified at 10d. Inside City Limits Director MD BALTIMORE CITY 1**XX** es 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2201 WALBROOK AVENUE, APT 401 21211 U.S.A. death Compieted by Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes **XX** No Specify: BLACK 3 XXVidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should ba filed within 7: th and Mental Hygiene. 7 is marked other then "n. Elementary/Secondary (0-12) College (1-4or 5+) CHILD CARE PROVIDER CHILD CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CARRIE LEE HAMER SAMUEL CHAPMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ruraf Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is 1250 TRAVIS VIEW COURT, GAITHERSBURG, MD DOROTHY MCMILLIAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ment of F tent: If its 1XX8urial 2 Cremation XX Removal from State ŏ permit. Page Department of Importent: If any injury of ' 4 □ Denation 5 □ Other (Specify)

21. Signature of Fact a Price icensee 9/11/04 ROBESON CHAPEL LAUREL HILL, NC 22. Name and Address of Facility FINK FUNERAL HOME, PA KELLY GREGORY FINK #MO1148 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician CANCER LUNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, United Section 1997, that initiated events Due to (or as a consequence of). Examiner usa as the burial-transit certificate be executad resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 ian/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death Month Day Year 5 Other (specify) P.0. Physic the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsv performed' 2 No 2 🗆 No 1 Yes Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? After 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 Smiller D30272 SEPT. 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h SALTIMONE MO 2000 W BAZTIMORE SMILLER 57. 1Homas 2. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** Vaar LARRY A. GILBERT SEPTEMBER 5, 2004 20:22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Say Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) Date of Birth (Month, Day, Year) **Funeral** Days 1[★M 2 F Director 218-54-0398 55 7/10/1949 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **show** ir than "neturel", or items 23a or 28e-f shov The Modest Exampler must be collised at Director BALTIMORE 1 ☐ Yes 2 ☐No PARKVILLE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1713 WESTON AVENUE 21234 USA by Funerai 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED othar treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fil Department of Health and Mental H Important: If item 27 is marked ott any jnjury or othar treumatic even pones. Be æ LEROY B. GILBERT, JR. 2 JEANNE A. ECKENRODE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL GILBERT SON BALTIMORE, MD 1760 AMUSKAI ROAD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) METRO CREMATORY, INC. 9/10/2004 CATONSVILLE. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD lathe 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HASOVO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Ente, Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No detached f P.O. 9 Unknown 9 Unknown Š signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has certificate 1 Yes 2 No in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Inpatient 2 1 XYes 2 No 22 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred after death. Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SEPT 5, 2004 DME 121809 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 95. PRASHU YO REL 2336 TIMONIUM MD MD 21093

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

SEP 0 9 2004

ORIGINAL

32. Registrar's Signature

			1 - For State Registrar	State of Maryla		artment of H rtificate of L		, ,	iene	2851.1
	P.L.		Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h	3. Time of Death
	Physici /Medic		William T. Groome					09	06 2004	8:25 A M
,	Examin	er	4a. Fecility Name (If not institution, give s Hammonds Lane Cen	ter Hammon			/n, MD 2	1225	Anne A	Irundel
	Funeral Director		5. Social Security Number 6. Sex 1凶	M 2□ F 7. Age (In y	rs. last birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Min		Year) 9. Birt	hplace (Stete or Foreign untry) W YOYK
	D		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	antien				
	Aanyla shor	ō	MD Anne Arun							10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	28a-	rect	10e. Street and Number	dei d	len Burr	10f. Zip Code		10	Og. Citizen of What Co	
	138 or	Funeral Director	107 Phelps Avenu	е		21061			U.S.A.	,-
	ema 2	ner		2. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (	Specify Yes or No-	14. Race - Ame	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23e or 28e-f show finp printing or other traumatic event, the Madical Examical transition at annexes.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:	no nican, etc.)	Specify: 1 th	
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215	hin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	furing most of we	orking		, ideally
Maryland 21215-0036	ed will ygien er the t, the	Соп	12		Heavy	Machine	Operato	r	Bethlehem :	Steel
and	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ime (First, Middle, M	faiden Sumame)	
7	should ind Men imarke umaric	င္	William Groome  19a. Informant's Name/Relationship (Type	a Print)	10h Maili	ng Addross (Stront s	Cory	Blankensh	ip City or Town, State, 2	F- 0 (1)
Ma	and 2 s salth an n 27 ls r		Betty Groome	e, Fintj					. MD 21061	ip Code)
ē,	f Heal		20a. Method of Disposition	208	. Place of Dispo	sition (Name of			• MD ZIOOI 20c. Location - City or	Fown, State
E O	Pages nent of int: If it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re  1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	len Have	natory or other place	ı	/2004	Glen Burni	o MD
Baltimore,	permit. Departm Importa any inju		21. Signature of Europeal Service Ucense	China and the second se		2. Name and Addres	s of Facility	Complete Street		and a second
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	Physician /Medical Examiner		23a. Part <sup>1</sup> . Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cruss on each line.	monia	er the mode of dying	g, such as cardia	c or respiratory arre	st,	Approximate Interval Batween Onset and Death
8760,	cate be executed bhysician and the burial-transit	ai Examiner	Sequentially list conditions, if any, issuing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons		n Acc	dlut			
687	tificate ng phys as the	edicai	0.							
.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pre- 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delification	very Day Year
ص	res that igned by be deta	y Ph	Part II. Other significant conditions conf	tributing to death but not	resulting in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds	w requires been sign should be	ed by	Conjestu	4 Heart	Failn	u		1 ☐ Ye	s 2□No 3 Pro	bably 4 Unknown
000	aw requisite been 2 should	Completed			ŕ			24a. Was an		opsy findings available
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Vital Records,	ysician: The lavis certificate has director, page 2	Be	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one		-
ot \	Physic this c	은	1 195 2 5 5 NO	ospital: 1 Inpatient 2			dursing i	7	nce 6 Other (Spec	ify)
uo	ding P h. After funer	tion	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	) 28b. Time of Injury	Work	at ? ∕es 2 ⊡No	28d. Describe how	w injury occurred	
Division of	f or Attending after death. Director: After I in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)		63 2 0 110	28f. Location (Str. City or Town,	eet and Number or Rui State)	ral Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death: To the Funeral Director: After this certifical completely filled in by the funeral director.	edicai Ce	29a. Certifier (Check only one) 1 Certifying Physical Examin	ician: To the best of my ker: On the basis of exam and manner stated.	knowledge, deatlination and/or in	n occurred at the tim vestigation, in my op	e, date and place inion, death occ	e, and due to the cal urred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	101		29c. License	nedmun	29	d. Date signed (Month	Day, Year)
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	X		30. Name and address of person who cor SRIDHAR. ATLUR	. 0 .	1	. 1)	dena	mp 21	122	10000
黎	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 9 2	32. Reofirar's Sig		1. 10	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 6 LUDEK 11:50 PM 08 PATRICIA 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 600D SAMARITAN BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7-31-60 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1□M 290F 220-76-17 Director MARYLAND Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location rel', or Items 23c or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No BALTI MORE BALTIMORE Director MA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21234 HARK death 1 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: white. Specify: 3 ☐ Widowed 4 ☐ Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) treumatic event, the Medical al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Analytical 4 nemist Jascoune 18. Mother's Name (First, Middle, Maiden Sumane) 17. Father's Name (First, Middle, Last) Be Mental 6/odek UTZI barbara 2 ewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and l 19a. Informant's Name/Relationship (Type, Print) 21 Parkwind Ct, perriit. Pages 1 and 2: Department of Health a Importent: If item 27 is any injury or other treuonce. BALTIMORE, MD 21234 Lewis 210dek tatke 20b. Place of Disposition (Name of cametary, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

\* 4 ☐ Donation 5 ☐ Other (Specify) STUDERAL CHAPEL- 9-12-04. Forest Hill, MD 22. Name and Address of Facility BALTIMORE, MD 21234. 21. Signature of Funeral Service Licery Kimbeil Seviota EVANS FUNERAL CHAPEL, 8800 HARFORD RO 23a. Part1. Enter the disease, or complication, that cause / the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List, nly one baute on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit IVER DISERSE END STA6F the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 PAILURE Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I à RELATED 1 Yes 2 No 3 Probably 4 Unknown CIRPHOSIS Completed 24b. Were autopsy findings available prior to completion of cause of death?
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LITKU LIYSAL 31. Date filed (Month, Day, Year) SEP 0 9 2004

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certified

BLUD BALTIMORE, MD, 21239 5601 LOCH PAVEN 32. Regi rar's Signature

Registrar

29c. License number

RESOUC

29d. Date signed (Month, Day, Year)

09/08/2004

			1 - For State Registrer	State of Maryla		artment of H			iene	01	00510
	Physic /Medi	ical	Decedent's Name (First, Middle, Las     Alice     4a. Facility Name (If not institution, give	. W.	Gobeli	AL CLUT		2. Date of Death Month Septembe	b Day	Year 2004	3. Time of Death 11:00 Å
	Exami Funeral		Gilchrist Cent 5. Social Security Number 6. Se	er 7. Age (In yr	rs. last birthday)	Tows		9 Date of Birth	I	Baltir 9. Birthr	
	Director		224-36-7041  Usual Residence of Decedent  10a. State 10b. County		75 Yrs.  City, Town or Lo		Tiodis Will.	Dec. 3,	1928		place (State or Foreign ntry) 1 O
	with the Mary sa or 28a-f sh	Funeral Director	Maryland Baltimor		Baltimo	10f. Zip Code		10	Og. Citizen of	What Cour	1 □ Yes 2 🛣 No
9800	hours after death with the Maryland turet; or items 23a or 28a-f show	by	8404 Kings Ridge  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		21234  Was Decedent of H f Yes, specify Cuba  1 □ Yes 2 □ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra	S.A. ce - Americ ack, White,	
121215-0036	ges 1 and 2 should be filed within 72 hours to Health and Mental Hygiene. If item 27 is marked other than "natural", or other traumatic avent. The Medical Exist.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Ce Manage	during most of work	S	Station	nary S	ŕ
Maryland	should be fi and Mental H s marked otl	To Be	17. Father's Name (First, Middle, Last)  Max Williams  19a. Informant's Name/Relationship (T)		19b. Mailir	g Address (Street	18. Mother's Name  Olive  and Number or Run	e (First, Middle, M Pouls al Route Number,	on		Code)
Baltimore, M	permit. Pages 1 and 2 should be fi Department of Health and Mental P Important: If item 27 is marked of any injury or other traumatic aven 900.8.		Johnnie Gobeli  20a. Method of Disposition  1 X Burial 2 Cremation 3 1  4 Donation 5 Other (Specify,  21. Signature of Tureral Service Libens	Removal from State	Place of Dispo unated Cres Memoria 22	sition (Name of patory prother place Gardens . Name and Addres	9-10-	-2004 Tuck Towso	oc. Location imoniu n Fune	· City or To Im Feral F	Maryland Home, Inc.
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68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Entire Uniderlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.							
O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 0 No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)			1	ite of delive	ry Day Year
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of	ding Phys I. After this funeral dir	ation; To B	examiner?  1  Yes 2 No   1  Yes 2 No   1  Yes 2 No   27. Manner of Death  1  Natural 5  Pending 2  Accident investigation	Hospital: 1 ☐ Inpatient 2 [ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	er: 4 🗆 Nursing Hor	me 5 Residen			Hospice
Division	To the Hospital or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Pface of Injury - At building, etc. (Spec	ify)			28f. Location (Stre City or Town,	State)		
	To the Hos within 24 ho To the Func completely f	Medical	29a. Certifier (Check only one)  1 Certifying Physical Exemination (Check only one)  29b. Signature and title of certifier	sician: To the best of my kner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the timestigation, in my op	inion, death occurre	ed at the time, date	se(s) and ma e and place, a	and due to	the cause(s)
•	<b>⊢</b> ≱ ⊢ ŏ		Mere	umpleted course of death (iii	~ <u>)</u>	D5	8303	-	-	,	o 2004
	JO Sta	ite	30. Name and address of person who co	32. Registar's Sign	nature				601 N Tows	. Char on, Mo	rles Stree d.21204
	Registr	ar	SEP U 9	ZUUA Clare	· K	drack .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician SEPTEMBER 2, 2004 ADDIE MAE GERALD 4:30 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FORT WASHINGTON HOSPITAL FORT WASHINGTON PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/17/1908 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 SOUTH CAROLINA 248-60-4829 96 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State show nem 47 is marked other then "naturel", or Items 23a or 28a-f shoi other treumetic event, the Medical Examiner must be notified at 1 XXes 2 □ No **Funeral Director** PRINCE GEORGES FORT WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11401 GRAGO DRIVE 20744 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes **XX**No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify: BLACK Specify: Be Completed by 3 XXidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental P Pages 1 and 2 should be STEPHEN REMBERT MARGIE (Unknown) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 11401 GRAGO DRIVE, FORT WASHINGTON, MD 20744 LILLIE PERRITT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 0 = 0 1 XX Removal from State permit. Page Department of Importent: If any injury or once. NORTON CEMETERY 9/10/04 MULLINS, SC <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 21. Sign (40) Funeral Service Idean 22. Name and Address of Facility FINK FUNERAL HOME, PA KELLY CRECORY FINK #MO1148 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest list ghly one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Betw Onset and De Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Se uentially list conditions: if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Que to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last physician a Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be o 3 ☐ Probably 4 ☐Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 21 No 1 Yes To the Hospitel or Attending Physicien: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🙀 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation death. I Director: A 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Records, Vital of Division

Box 68760,

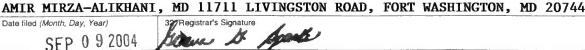
P.O. I

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



SEP 0 9 2004

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

29c. License number

D46046

29d. Date signed (Month, Day, Year)

			_	State of Maryland	/ Department of Health and	Mental Hygie	ene
		•	For State Registrar	0.000	Certificate of Death		N2004 28545
	Physicia		1. Decedent's Name (First, Middle, Las	Malachi	Gamble	2. Date of Death Month	Day Year 4 2004 10,00 a.M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dec	ath	4c. County of Death
_			5. Social Security Number 6. Se	hall 7. Age (In yrs. las	Balto st birthday) If Under 1 Year   If Under 24 Hi	's. 8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director			M 20F 83	Yrs. Months Days Hours Min		Gountry) S.C.
	yland		10a. State 10b. County	10c. City,	Town or Location		10d. Inside City Limits
	should be filed within 72 hours efter death with the Maryland of Mental Hyglene. marked other than "natural", or Itams 23a or 28a-f ahow imatic event, it a Madical Exactli at mail be mullified at	by Funeral Director	Md 10e. Street and Number	NA Ba	10f. Zip Code	100	1 Ves 2 □ No
	23a or	ai Di	3854 Dolfield	Avenue	21215		U.S.A
	Itams	uner	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	72 hours efter natural', or Ita dical Examina	byF	3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black
15-0	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "natur any injury or other traumatic event, ITa Madical any injury or other traumatic	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking 16	b. Kind of Business/Industry
2121	d within giene. er than " ir e Ma	omo	Elementary/Secondary (0-12)  4th grade	College (1-4or 5+)	Construction Wo.	rker	
	be filed ital Hygik id other evant, II	To Be C	17. Father's Name (First, Middle, Last)	10/0	18. Mother's N	ame (First, Middle, Ma	
Maryland	2 should and Mer is marke sumatic	ို	10MMU COO	Mble Type, Print)	19b. Mailing Address (Street and Number or I	e Havris Aural Route Number, C	
-	and 2: ealth ai m 27 is har trau		Carrie Cous	er Sister	3854 Dolfield	Avenue	
ore	iges 1 it of He if itar		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	ce of Disposition (Name of netery, crematory or other place)	Date 20	c. Location - City or Town, State
Baltimore	permit. Page Department Important: If any injury or once.		*4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen.		22. Name and Address of Facility	9-1004 F.	H. West
ä	Depar Depar Import any ir		Yola 11	Jareh	4300 Waba	sh fre	Balto, Md 21215
			23a Fart1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final	lications that caused the death. The cause on each line.	Do not enter the mode of dying, such as cardi	ac or respiratory arrest	t, Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Colou  Due to (or as a conseque	nce of):		
н	Examiner		Sequentially list conditions,	6. Severe	Ane-ig		
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	`C \\\ \( \sqrt{1} \)	-art 16	Film
ó,	ate be executed hysician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a conseque	nce of):	14	
68760	cate by physic the bu	dicai		d_Malm	station		
Box 6	death certifica e attending ph id for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal d			23d. Date of delivery
O. B		by Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of dea			Month Day Year
ص	s that the ined by the e detache	y Ph	Part II. Other significant conditions or	ontributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
Records,	w requires been sign should be	ted t	weight	- hoss		1 ☐ Yes	2 No 3 Probably 4 Munknown
Rec	e la hes je 2	Completed				24a. Was an autopsy performe	
Vital	sician: Th certificate rector, pag	0	25. Was case referred to medical		26. Place of D	1 ☐ Yes 2 ☐ eath (Check only one)	No 1 ☐ Yes 2 € No
of V	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF			ce 6 Other (Specify)
ono	fter fter	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	8b. Time of Injury 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred
Division	or Attendir ifter death. Director: At in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospital or Attendit within 24 hours after death.  To the Funaral Director: A completely filled in by the fu	edicai Ce	(Check only 2 Medical Exam	niner: On the basis of examination	edge, death occurred at the time, date and pla in and/or investigation, in my opinion, death oc		
	Fo the within 2 Fo the complex	Med	one) 29b. Signature and title of certifier	and manner stated	29c. License number	29d	. Date signed (Month, Day, Year)
	^		1/ Jue B	139,0	ud D5542	4 9	17/04
	' }-		30. Name and address of person who	01-1112	1 - 40 1.11	10.1.11	111 A DIDD D
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	wou weather AV Co	2 CUSVIIIE	- my 41260
	Regist		SEP 0 9 2004	Denvie	sporks		

			1 - For State Registrar	State of M	/larylan		artmen rtificat			and M		Reg. No.		28514	,
H	Physici	an	Decedent's Name (First, Middle, Las	,							2. Date of De Month	Day	/ Yea	3. Time of Dear	.ń
	/Medic	al	ARTENNIS C. HENI  4a. Facility Name (If not institution, give		r)		4h City	Town or	Localion o		EL LEMI		7, 200 County of De		IVI
	Examin	er	Saint Joseph			cer	40. Oily,	10411, 01		WSO	ท	10.		timore	
	Funeral		Social Security Number     6. S		Age (In yrs. I	last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th Vear	9. E	Sirthplace (State or For Country)	eign
	Director		217-20-8566	xM 2□F	78	Yrs.	Months	Days	Hours	MIN.	6/25/			ARYLAND	
	and w	-	Usual Residence of Decedent  10a, State 10b, County		10c. City	y, Town or Lo	ocation							10d. Inside City Lir	nits
	Maryli f aho	ō	MD BALTIN	ORE:		PARKVI								1 □ Yes 2 □	
	28a-	Director	10e. Streel and Number	101 (1)		Hutvi	10f. Zip	Code				10g. Citi	izen of What	Country?	
	h with		1751 AMUSKAI ROA	MD.			21	234				Ţ	JSA		
	ems seriou	Funerai	11. Marital Slatus	12. Was Deceder Armed Forces	s?	S. 13.			spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)			merican Indian,	
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21215-0036	in 72 hours after death with the Marylan n "natural", or Items 23a or 28a-f ahow Valical Ezer, is er must be notified at		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates	: WWI]		dent's Usua	al Occupa	ition			16b Ki	MI ind of Busines	HITE	
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	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, Last)								(First, Middle	, Maiden	Sumame)		
yla		2	CLINTON HENDRICKS	SON							URSEY				
Maryland	C1 00 02		19a. Informant's Name/Relationship (		.arme	1					n Route Number				
	1 and Health em 27 ther tr		BETTIE M. HENDRIC  20a. Method of Disposition	VY2OIA	WIFE	lace of Dispo	AMUSI sition (Nan	ne of	1		TIMORE,		2123 <sup>4</sup>	or Town, State	
Baltimore,			1 🛣 Burial 2 □ Cremation 3 □		, c	emetery, crei ANEY	matory`or o	ther place							
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Ba	permi Depa Impo any ir		Hensthy 1	1. Hus	4					711	D. TOWS			1286	7 •
r	<b>H</b>   H		23a. Part1. Enter the disease, or company shock, or heart failure. List only	olications that caus	ed the death									Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	a SEPSI										Onset and Death	
	/Medical		resulting in death)	u	as a consequ	uence of):									
	Examiner	_	Sequentially list conditions,	b. PNEUM											
	ed isif	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequ	uence or):								1	
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8760,	ate be execufed hysician and the burial-transif	icai	l	d											
9	death certificate be execufed e attending physician and nd for use as the burial-transif	ed													
Вох	leath certifica attending ph I for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			]Ectopic pr	egnancy				2	23d. Date of d Month	lelivery Day Year	
O. E	e dea the af	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5	Other (sp	ecify)					WORTH	Day	
σ.	requires that the de leen signed by the a hould be detached t		Part II. Other significant conditions c	ontributing to death	bul nol resu	ulting in the u	nderlying c	ause dive	n in Part I.		23e. Did t	obacco u	se contribute	to the cause of death?	?
ds,	signe d be	d by	ATRIAL FIBRILLATI			J	, , , ,	3			10	Yes 20	<b>X</b> No 3□1	Probably 4 Unkno	own
Sor	w require been sig should t	ete	GASTRIC ULCER								24a. Was	an	24b Were	autopsy findings availa	ıble.
Re	The law ate has b page 2 sl	Completed	GASTRIC ULCER								autor perfo	osy ormed?	prior to death?	completion of cause	of
Vital Records,	ician: Th certificate rector, pag	a)	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes	2 A No	1 U Y	es 2 No	
	di is	ToB	examiner? 1 ☐ Yes 2 🗶 No	Hospital: 1 Inpa	tient 2	ER/Outpatier	nt 3 DC	)A Othe	r: 4 □ Nur	rsing Ho	ne 5 Resi	dence 6	5 □Other (Sp	pecify)	
n of	ding Ph J. Affer th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of In (Month, L	ijury Day Year)	28b. Time of Injury	f 2	8c. Injury Work	at ?	2	28d. Describe l	how injur	y occurred		
Division	or Attending after death. I Director: Affe d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be				М		′es 2□N		2011	0			
Σ	or At after d Direct in by	illi	4 ☐ Homicide determined	280. Flace of 1	etc. (Specify	ome, farm, str /)	reet, factory	r, office		1	City or To			Rural Route Number,	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Affer completely filled in by the funer		29a. Certifier 1 Certifying Ph	ysicien: To the be	st of my know	wledne death	h occurred	at the tim	e, date and	d place :	and due to the	cause(s)	and manner	as stated	
	e Hospital 124 hours a e Funeral l letely filled	edicai	(Check only 2 Medical Exen	niner: On the basis and manner	of examinat	tion and/or in	vestigation,	in my op	inion, deat	h occurr	ed at the time,	date and	place, and de	ue to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	\ //	1		290	. License	number			29d. Dat	e signed (Moi	nth, Day, Year)	
•			• (	15m	5	on		0 37	254			91	7/00	1	
	11/		30. Name and address of person who	completed cause of	f death (Item	1 23а) (Туре,	Print)								
	10,		BOON P. LIM M. D	7671	OSLEI	RDRI	VE T	DWSC	IN MA	RYL	AND 2:	1224			
	Sta Registr		31. Date filed (Month, Day, Year)  SED 0 9 2004	Aene Mens	strar's Signa		oork	1							
			VER 11 3 4 11 114	/mar / F	/ -		V								

		1	. For	partment of Health and M Pertificate of Death	ental Hygiene	28547
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Johanna Elizabeth Horner		2. Date of Death September 5, 200	3. Time of Death 8:00pm M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Carroll Hospital Center	4b. City, Town, or Location of Death Westminster	4c. County of De Carrol	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 82 Yrs	Months Davs Hours Min.	8. Date of Birth (Month, Day, Year) 1922 Aug. 23, 1922	Birthplace (State or Foreign Country)
	show	j.	Usual Residence of Decedent	r Location Sykesville		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the N ta or 28a-f t be notifi	Direct	10e. Street and Number 1710 Keel Drive	10f. Zip Code 21784	10g. Citizen of What	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene item 27 is marked other than "natural", or items 23s or 28a-f show other traumatic event, Ita Medical Examiner must be natified at	by Funeral Director	11. Marital Status  Y 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	I I3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ☑ No Specify:	city Yes or No-Rican, etc.)  14. Race - Ar Black, W	
Baltimore, Maryland 21215-0036	vithin 72 hour ne. han *natural	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of working by DO NOT use retired)  Dimemaker	16b. Kind of Busine  Domesti	·
1d 2	e filed v	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maiden Sumame)	<u> </u>
rylar	2 should be f n and Mental i is marked of raumatic eva	ToE	Frank Idzi  19a. Informant's Name/Relationship (Type, Print)  19b. M	Mary dailing Address (Street and Number or Rura		a. Zin Code)
Ma	and 2 stall and 127 is retraur			.O Keel Drive Sykesv	_	, 20 3030)
imore	permit. Pages 1 and 2 Department of Health Importent: if item 27 i any injury or other tre		t El Busial 2 Comption 3 Demoval from State	isposition (Name of crematory or other place) anislaus Cemetery 9/	20c. Location - City 10/04 Baltimore	
Balt	permit. Departr Importe any inji		21. Signature Funeral Service Licensee	HAIGHT FUNERAL HOME Sykesville, MD 2178		ox 195)
	Pnysician		23a. Part1. Enter the disease, or complications that daused the death. Do not shock, or heart failure. List only one cause on-each line. Immediate Cause (Final disease or condition	enter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to ( r as a consequence of)			
8760,	ate be executed thysician and the burial-transit	al Examiner	Sequentially list conditions, if any, isading of immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of)			
O. Box 687	The law requires that the death certificate tte has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of 6 Month	delivery Day Year
۵.	uires that t n signed by ild be detai	by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco use contribute 1 ☐ Yes 2 ☐ Mo 3 ☐	to the cause of death?  Probably 4 ①Unknown
Vital Records,		Completed			autopsy prior performed? death	autopsy findings available o completion of cause of ? es 2 □ No
Vita	sician: certific rector,	o Be (	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 mpatient 2 ER/Outp	26. Place of Death atient 3 DOA Cther: 4 Nursing Hor	n (Check only one) me 5 ☐ Residence 6 ☐ Other (S	naciful
of	ling I. After fune	H 1	27. Manner of Death  1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day Year)  Inju 2 ☐ Accident investigation	ne of 28c. Injury at	28d. Describe how injury occurred	респу
Division	of or Attending after death. I Diractor: After d in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	s, street, factory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
	To the Hospitel or within 24 hours after To the Funaral Direction completely filled in h	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, (Check only one)  2 Medical Examiner: On the basis of examination and/and manner stated.	or investigation, in my opinion, death occurre	ed at the time, date and place, and o	lue to the cause(s)
•	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c, License number D 20806	29d. Date signed (Mo	onth, Day, Year)
	\/		30. Name and address of person who completed cause of death (Item 23a) (T)  PATRICK TURNES, MD 1000 KIBERT	(y AD 102 ELDER (A	WAL M7 217	84
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 0 9 2004 37 Registrar's Signature	29c, License number D 20806  (Pe. Print) TO 2 ELDERS B		~

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrament ITEM #5 per FH,G835,9/19 Provide te of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Haviland, Sr. 2004 Michael September 6 11:30 pM Terrence /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 11700 Jenifer Road Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug., 20,1935 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. S**219-30-431-2**5 **Funeral** Days Hours Min 1**X** M 2□ F Yrs. Aug., Maryland 219-30-5562 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits wode r than "natural", or iteme 23a or 28e-f ehov the Medical Examinat must be notified at 1 TYes 2 No Director Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 11700 Jenifer Road 21093 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐XNo Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Heelth and Mental Hygiene. Importent: If Item 27 is marked other than "nat any Injury or other treumatic event, the Medica once. Elementary/Secondary (0-12) College (1-4or 5+) Assistant Greenskeeper Golf Course 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stephen A. Haviland Eleanor Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Haviland/spouse 11700 Jenifer Road Timonium, MD 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c Location - City or Town State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mays Chapel Cemetery 09/10/2004 Timonium, MD. \* 4 Donation 5 Dother (Specify) 21. Signature of Fulheral Service Lensee 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc S. Coster 1050 York Rd. Towson, Md. 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cenoma **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à page 2 should be 1 Tes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of caese of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 1 ☐ Yes 2 1 s after deau...
rel Director: After this ceru... Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 200 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funerel ( 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed Month, Day, Year) 29c. License number

State Registrar

29b. Signature and title of certifier

John 31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004 Regist

Down

DHMH 17 Rev 1/2001

OSlee Drive #302

MD 21204

KENNETH R. HOPKINS 04 - 5770DAP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. edent's Name (First, 2. Date of Death 3. Time of Death Month Day 7, **Physician** 2004 7:50a /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY UNIVERSITY HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 5. Social Security Number Birthplace (State or Foreign
 Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral №** M 2 F Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 2719 marked other than "naturel", or Itams 23e or 28erf ehow other treumstic event, the Medical Exert instrumet to notified at 1 No 2 No Director nore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funerai Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should ba filed within 72 hours after on and Mental Hygiene. 1 e marked other than "naturel", or Itar 1 ☐ Yes 2 X If Yes, Give Year or Dates: Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) d of Business/I econdary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, is 1 and 2 s of Health an item 27 le Date 20c. Location - City or Town, State Method of Disposition Pages 1 permit. Pages Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit death certificate be executed Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
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4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) lace of Injury - At home, farm, street, factory, office determined building, etc. RE 77 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check o the within To the 29d. Date signed (Month, Day, Year) SEPTEMBER 8, 2004 29c. License number 29b. Signatur OCME and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name 111 Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

Amend item # 24a per Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Hudock Santa 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE KOSEDALE HOSPITAL FRANKLIN SQUARE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 25, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex <sup>Year)</sup> 1923 **Funeral** 1 □ M 2 🖫 F Pennsylvania 193-16-8554 81 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 77 is marked other than "natural", or items 23a or 28a-f show traumatic event. Its Medical Exam for motified at 1 ☐ Yes 2 👿 No Directo Maryland Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 614 B Harborside Drive 21085 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Department Store 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ould be f Mental I Rose Pace Samuel Abate 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is n any injury or other traum once. Mrs. Rosemarie Moerschel (dghtr) 69 Neptune Drive, Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem'l Park 9/4/04 Elkridge, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OVARIAN CANCER Physician METASTATIC 6 years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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1 Yes 2 No 4☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 2 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No by the f 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide \_ filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 0 0 ND Hanowellad RES 0000 30. Name and address of person who empleted cause of death (Item 23a) (Type, Print) FRANKLIN SQUARE DR. BALLINORE HANOWELL 9000 MICHMEL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State bean & sporte SEP 0 9 2004 Registrar

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ORIGINAL

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25. Was case referred to medical examiner?  1			Con						perform	led? _   de	ath?		
The state of the s	Vite	sician certifi recto	00	examiner?	Hospital:		Othe		and the second				
Month, Day Year   Injury   Work?   Street and Number or Rural Route Number of Bural Route Number or Rural Route Number or Street and Number or Rural Route Number or Rural Rou	of	Phys or this oral di		I Tes 2 No	1 Inpatient 2 I		3∐ DOA	4 Nursing Hor					-
3 Suicide 4 Homicide 4 Homicide 4 Suicide 4 Homicide 4 Homicide 4 Homicide 5 Suicide 4 Homicide 5 Suicide 4 Homicide 6 Suicide 8 Suicide 6 Suicide 8 Suicide	ion	nding ath. r: Afte e fune	atlor		(Month, Day Year)	Injury							
	ivis	r Atte	tific		28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office	:	28f. Location (Str City or Town	eet and Number State)	or Rural	Route Number,	
O late of the state of the stat	٥	ospital or A hours after uneral Dire ly filled in by											
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)		a Hos	dica	(Check only 2 Medical Exam	ner: On the basis of examinat	wledge, death ion and/or inv	occurred at the tim estigation, in my op	e, date and place, a pinion, death occurr	and due to the ca ed at the time, da	use(s) and manr te and place, an	ner as sta d due to t	ted. he cause(s)	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	:	To the within To the compl		29b. Signature and title of certifier	/		29c. License	number	29	d. Date signed (	Month, D	ay, Year)	
MD D 314 64 9/9/04	•			120	Many	MI	D	31464		910	710	4	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SHOALLS A. HASHMI 82 (N. Enlaw St. Smite 308 Back. mg		n		C 1 4	ompleted cause of death (Item	(/ ) .	Print)	la CI	C - A	300	Rail	6 MO 2	1
				, , , , , , , , , , , , , , , , , ,	1743 ton 1		1V. 2n	rows of	smle	200	الماهدا	w. 171 21.	20
State Registrar SFP 0 9 2004  SFP 0 9 2004  State  SFP 0 9 2004					La riogistial's signal	1	2.11						

		1	For Amend Item #2015-18 RegisAMEND ITEM #1,7,17&	of Maryland 635 Personal Perso	arthont of Health and N Biscare of Realth	Mental Hygien	
ī	Physicia		J. Decedent's Name (First, Middle, Last)		HENWOOD, SR.	2. Date of Death Month	ay Year G A M
) )	/Medic Examin	er	a. Facility Name (If not institution, give street and nu		4b. City, Town, or Location of Death	40	c. County of Death
Ī	Funeral Director		6. Sex 1 M 2 F	7. Age (In yrs. last birthday)  67 68 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Year Oct. 9, 1	9. Birthplace (State or Foreign Country) 935 Illinois
	death with the Maryland ms 23a or 28a-f show r must be richtlied at		Usual Residence of Decedent  10a. State  10b. County  Maryland  n/a	10c. City, Town or Lo			10d. Inside City Limits 1
	with the a or 28a Libe rivili	Direc	10e. Street and Number  1437 Patapsco Street		10f. Zip Code 21230		itizen of What Country? ted States
	be filed within 72 hours after death with the Marylan Hygiene.  to Hygiene.  to ther than "natural", or tems 23a or 28a-f show event, the Medical Examinar must be redified at	by Funeral Director	11. Marital Status 12. Was Dec	2 No	Was Decedent of Hispanic Origin? (St If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	within 72 hou ene. then "natura to Medicul E	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College 12 years	(1-4or 5+) 16a. Dece (Give life.	dent's Usual Occupation I kind of work done during most of work DO NOT use retired)  DOUSEMAN	king	Kind of Business/Industry
Maryland 2	uld be filed fental Hygie rked other tic event, t	To Be Co	17. Fathers Name (First, Middle, Last)  JOHN HENWOOD  John Hernwood	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	18. Mother's Nam	e (First, Middle, Maide Stragman	n Sumame)
Mary	s 1 and 2 should be f Health and Mental item 27 Is marked other traumatic ev		19a Informant's Name/Relationship (Type, Print) JOAN LYNCH HEMOOD (WIF	_\	ng Address <i>(Street and Number or Ru</i> Patapsco Street I		
Baltimore,	m O		20a. Method of Disposition  1. Burial 2 □ Cremation 3 □ Removal from  4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo		Date 20c. I	Location - City or Town, State
Baltı	permit. Page Department of Important: If any injury or once.		21. Signal ore of Funeral Survive Licensee		2 Name and Address of Facility CCUITY Polyniak Fu 30 E. Fort Ave. Ba		
	Physician	i i	23a. Part : Enter the disease, or complications that shock of heart failure. List only one cause on Immediate Cause (Final disease or condition		ter the mode of dying, such as cardiac		Approximate Interval Between Onset and Death
	/Medical Examiner		Cox	o (or as a consequence of):			- Yn
8760,	be executed sician and burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	(or as a consequence of):	m		Y21
Box 6	ath certificate ittending phy: or use as the	Physiclan/Medical	23b. was decedent pregnant 1 Live	gnant at time of death 5[	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ds, P.O	uires that the de signed by the a Id be detached t	by	Part II. Other significant conditions contributing to	death but not resulting in the u	underlying cause given in Part I.		ouse contribute to the cause of death?  2 No 3 Probably 4 Unknown
of Vital Records,	The law requate has been page 2 should	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
Vita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?  1  Yes	Inpatient 2 ER/Outpatie	Othor	th (Check only one) ome 5 - Residence	6 ClOther (Specify)
	Attending Physician: ir death. ector: After this certifics by the funeral director. I	itlon; To		e of Injury onth, Day Year)  28b. Time of Injury		28d. Describe how inj	
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Certification:	3 Suicide 6 Could not be 28e. Pla	ce of Injury · At home, farm, st Iding, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or Atwithin 24 hours after of To the Funeral Direct completely filled in by	edical C	(Check only 2 Medical Examiner: On the	he best of my knowledge, dea basis of examination and/or in anner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occur	, and due to the cause( rred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier		29c. License number		Pate signed (Month, Day, Year)
•	۵ . ۱۸-		30. Name and address of person who completed ca	nuse of death (Item 23a) (Type	D34974 No. Print) Nyles Street, 3	) D.Q.	ft, 7th 2004
	OFIVE		CHARY MEHTA, MD 6	Bright Signatural	erpes Street, 'S	altimore	, 14021230
	St Regist	ate rar	31. Date filed (Month, Day Year) 9 2004 32.	1	7		

HENWOOD, JAMES

		1 - State Amend Item 21	per FH,G83	5,09/09/	intilient of a	Death	Re	a. No. 1	20000
		1. Decedent's Name (First, Middle, Last)					2. Date of Death	- 4 U U 4	3. Time of Death
Physic /Med		LOVELLA		ItAI	VKING		Month SEPTEMBE	Day Yea	
Exami	ner	4a. Fecility Name (If not institution, give s The Johns Holk 5. Social Security Number 6. Sex	ins Huspit	vrs. last birthday)	Bultimo	If Under 24 Hrs.	8. Date of Birth	4c. County of D	Birthplace (State or Foreig
Director		579 - 62 - 3452 15 Usual Residence of Decedent	M 2₹ 5	7 Yrs.	Months Days	Hours Min.	642 - 61 -	71947 (	seorgia
yland		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
e Ma	ctor	Md PG		Laur	el				ty∏Yes 2 □ No
3a or 28	I Director	10e. Street and Number 8701 Char Ct #	23		10f. Zip Code	20708	10	g. Citizen of What	
within 72 hours after death with the Maryland jiene. rthan "natural", or Items 23a or 28a-1 show the Medical Exemi or must be reditted ut	by Funeral	11. Marital Status  1 □ Never Married 2 🛣 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates:	If	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. Black
2 hou		15. Decedent's Edu	cation		ent's Usual Occup		1	6b. Kind of Busine	ss/Industry
within 7 ene. than "n	ompleted	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	,			
	Con	12th		Ma	intenar	nce		JS Treas	sury Dept.
ed all be	To Be (	17. Father's Name (First, Middle, Last) Charle	es B. Wats	on		18. Mother's Name	(First, Middle, M SSIE	aiden Sumame) Wal	^d
C C D ==	-	19a. Informant's Name/Relationship (Ty, Reed Hawkir	pe, Print) ns (husba	nd) 870	g Address <i>(Street a</i> )1 Char	and Number or Rura Ct #23,	Laure Laure	City or Town, State	20708
of Health of Health Item 27 i		20a. Method of Disposition		b. Place of Dispos	sition (Name of natory or other place		ate 2	0c. Location - City	or Town, State
Pages nent of I ant: If It		1 XBurial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ill Cer	m̂.  09−1	1-2004	Suitlar	nd, Md.
permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License  Terry A. Aust				₹ofysilter th Stree			
		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the c						Approximate Interval Between
nysician	4 1	Immediate Cause (Final disease or condition	INTERSTIT	AL LUNG	DISEAS	E			Onset and Death
/Medical		resulting in death)	Due to (or as a con	sequence of):					
Examiner	Jec	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequence of):					
cate be executed physician and the burial-transit	cal Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
	ᇴ								
it the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregnancy Other (s <i>pecify</i> )			23d. Date of o Month	delivery Day Year
signed signed d be de	by	Part II. Other significant conditions cor PULMONARY HYPET	_	resulting in the un	derlying cause give	en in Part I.			to the cause of death?  Probably 4 □Unknown
e law has b je 2 si	ompleted	PULMONARY BOEM	A				24a. Was an autopsy perform	prior t ed? death	
Ician: Th certificate ector, pag	o C	25. Was case referred to medical				26. Place of Death			es 2 🖾 No
Physician: this certific ral director,	0.0	examiner? 1 ☐ Yes 2 ☑ No	lospital:	2 ER/Outpatient	3 DOA Othe	0.5		ice 6 Other (S	necify)
Ilng After Une	tlon; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea.	28b. Time of	28c. Injun Work	at 2	8d. Describe hov		Journey
al or Attendl s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, stre	eet, factory, office	2	8f. Location (Stre City or Town,		Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Director completely filled in b	edical (	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the time estigation, in my op	ne, date and place, a pinion, death occurre	and due to the cau ad at the time, dat	use(s) and manner e and place, and d	as stated. ue to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License	e number	29	d. Date signed (Mo	nth, Day, Year)
		In Sheelu	1 reed, n	U.D.	RES-	000	SE	PTEMBER	= 5 2004
5		30. Name and address of person who co		Item 23a) (Type, I	,	600 NORTH	WOLFES		LTIMORE RYLAND 2128

DHMH 17 Rev 1/2001

ORIGINAL

PG  Innon Road,  12. Was Deceden Armed Forces 1 (Yes 2 Condition of the Co	Age (In yrs. las 56  10c. City, 1  F 0  The Ever in U.S. Sor 5+)  1 OW a y  Y  Y  Seed the death. Seeps is as a consequer	Silv  Silv  Silv  If Under 1 Yes  Months Dar  Town or Location  The Washing  10f. Zip Cod  2  13. Was Decedent of If Yes, specify Code in the Second of Seco	m, or Location of Death Ver Spring Sar If Under 24 Hrs. Hours Min.  3 ton  de 20744  of Hispanic Origin? (Specuban, Mexican, Puerto No Specify:  Coupation one during most of works tired)  Tech  18. Mother's Nam B  reet and Number or Rur Cannon Rd  of place)  Cem. 09- ddress of Facility  A  3	8. Date of Birth  8. Date of Birth  J Month, Day ye  J U I y 2,  10g.  10g.  ecify Yes or No- Rican, etc.)  sing S  e (First, Middle, Maice  etty  al Route Number, Cit.  pate 20c  07-04 C  ustin R0  821 14th	Citizen of What Cou  US  14. Race - Amer Black, White Specify:  Eliza  ten Sumame)  Bell  ty or Town, State, Zi ash. Md.  Location - City or Thelten has  yster Fu	pplace (State or Foreign and Sh. DC  10d. Inside City Limits 1 1 2 Yes 2 □ No untry?  ican Indian, etc.  3 1 a C k industry a beth Hos  ip Code) 20744  Fown, State
property of the property of th	Age (In yrs. las 56  10c. City, 1  F 0  The Ever in U.S. Sor 5+)  1 OW a y  Y  Y  Seed the death. Seeps is as a consequer	4b. City, Town Silv Washing Yrs.  If Under 1 Ye Months Day  Town or Location  The Washing  10f. Zip Cod  2  13. Was Decedent of If Yes, specify Control of Work and of Work and inference of Do Not use report of the Do Not use report of the Poly of	gen Spring  Bear If Under 24 Hrs.  Hours Min.  Gen Address of Facility  Address of Facility  A 3.	8. Date of Birth J. Month. Dax ye J. Wonth. Dax  109.  ecify Yes or No- Rican, etc.)  ing Se (First, Middle, Maice etty al Route Number, Cit.  Ft. W Date 20c 07-04 C ustin Ro 821 14th	Citizen of What Cou  US  14. Race - Amer Black, White Specify:  Kind of Business/Int  t. Eliza ien Sumame) Bell ty or Town, State, Zi ash. Md. Location - City or Thelten has  yster Fu	place (State or Foreign as h. DC  10d. Inside City Limits  1 Yes 2 \( \) No  untry?  ican Indian, . etc.  3 1 a c k  ndustry  a beth Hos  ip Code) . 20744  Town, State am, Md  uneral Hoi . NW Wash  Approximate Indiany Approxim
PG  Innon Road,  Innon Road,  Innon Road,  Inno Road,	Age (In yrs. las 56  10c. City, 1 F 0  not Ever in U.S. s? No s:  or 5+)  1 Oway  y  y  20b. Place cert Mar  Mar  seed the death. Seepsis as a consequer	If Under 1 Ye Months Day  Town or Location  The Washing 10f. Zip Cod 2  13. Was Decedent If Yes, specify Cod 1 Yes, specify Cod	Bar If Under 24 Hrs.  Bys Hours Min.  Cuban, Mexican, Puerto Morking Mexican, Puerto Morking Most of work Min.  Tech  18. Mother's Nam  Bys Hours Min.  Cannon Rd  Bys Hours Min.  Cem. 09 -  ddress of Facility  A	al Route Number, Cit.  The Company of Birth Market Street, Middle, Maice tty  al Route Number, Cit.  The Company of Compa	Citizen of What Cou US  14. Race - Amer Black, White Specify: E  . Kind of Business/li  t. Eliza den Sumame) Bell by or Town, State, Zi ash. Md Location - City or Theltenha	10d. Inside City Limits  1
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nnon Road,  12. Was Deceden Armed Forces 1 (X) Yes 2 If Yes, Give Year or Dates:  1. (C. Holl Ship (Type, Print)  1. Holloway  1. (Specify)  1. (Specify)  1. (Specify)  1. (Specify)  1. (Specify)  1. (Specify)  2. (Specify)  3. (Specify)  4. (Specify)  5. (Specify)  6. (Specify)  6. (Specify)  7. (Specify)  8. (Specify)  8. (Specify)  9. (Specify)  1. (Specify)  1. (Specify)  1. (Specify)  1. (Specify)  2. (Specify)  3. (Specify)  4. (Specify)  5. (Specify)  6. (Specify)  6. (Specify)  7. (Specify)  8. (Specify)  9. (Specify)  9. (Specify)  10. (Specify)  11. (Specify)  12. (Specify)  13. (Specify)  14. (Specify)  15. (Specify)  16. (Specify)  17. (Specify)  18. (Specify)  19. (Specify)	nnt Ever in U.S. s? No s: or 5+)  l oway  y  y  20b. Plac cen Mar  Mar  Sed the death. Se p S i S as a consequer	10f. Zip Cod  2  13. Was Decedent If Yes, specify C  1 Yes, specify C  1 Yes, specify C  16a. Decedent's Usual Oc (Give kind of work of iffe. DO NOT use re  Domestic  19b. Mailing Address (Str. 1401 01d C  ce of Disposition (Name of netery, crematory or other yland Vet.  22. Name and Ad  Do not enter the mode of	de 20744 207	ecity Yes or No-Rican, etc.)  ing  see (First, Middle, Maice etty  al Route Number, Cit.  The Part of Company	US  14. Race - Ameri Black, White Specify: E  . Kind of Business/It  t. Elization Sumame)  Bell  by or Town, State, Zitash. Md.  . Location - City or Theltenham  yster Fu	ican Indian, etc.  3 lack  3 lack  abeth Hos  ip Code)  20744  Town, State  am, Md  Interval Hot  Approximate Interval Between
12. Was Deceden Armed Forces 1 Key September 1	nt Ever in U.S. s? No s: No s: I oway  y  y  te	13. Was Decedent If Yes, specify Control of the Yes, specify Control of Yes, camalory or other, yes	20744  20744  Of Hispanic Origin? (Specuban, Mexican, Puerto No Specify:  Coupation one during most of work Tech  18. Mother's Nam  Breet and Number or Rur Cannon Rd  of place)  Cem. 09-  ddress of Facility  A	ecity Yes or No-Rican, etc.)  ing  see (First, Middle, Maice etty  al Route Number, Cit.  The Part of Company	US  14. Race - Ameri Black, White Specify: E  . Kind of Business/It  t. Elization Sumame)  Bell  by or Town, State, Zitash. Md.  . Location - City or Theltenham  yster Fu	ican Indian, .etc.  Black Industry  abeth Hos  ip Code) . 20744  Fown, State  am, Md Interval Holy Approximate Interval Between
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c. Holl ship (Type, Print) Holloway  1 3   Removal from State (Specify) a Licenses or complications that cause st only one cause on each  Due to (or a	loway  y  20b. Plac cem Mar  Mar  Sed the death. line. Sepsis as a consequer	19b. Mailing Address (Sm. 1401 01d Core of Disposition (Name of Disposition), crematory or other by land Vet.  22. Name and Address (Sm. 19b).	18. Mother's Nam  Breet and Number or Rur Cannon Rd  of place) Cem. 09- ddress of Facility  A	e (First, Middle, Maidetty  al Route Number, Cit  , Ft. W  Date 20c  07-04 C  ustin Ro  821 14th	ten Sumame) Bell ty or Town, State, Zi ash. Md. Location - City or T heltenha yster Fu	ip Code) 20744  Town, State am, Md  uneral Ho Approximate Approximate Interval Between
C. Holl ship (Type, Print) I. Holloway  I. 3 □ Removal from State (Specify) a Licensee or complications that cause st only one cause on each  Due to (or a	y 20b. Placem Mar Mar Seed the death. Seepsis	1401 Old (Control of the American Control of the Ameri	reet and Number or Rur Cannon Rd of place) . Cem. 09 –	etty al Route Number, Cit. , Ft. W Date 20c 07-04 C ustin Ro 821 14th	Bell ty or Town, State, Zi ash. Md. Location - City or T heltenha yster Fu	own, State  am, Md  uneral Ho  NW Wash  Approximate  Interval Between
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or complications that cause st only one cause on each  Due to (or a	mar Mar Mar sed the death. Sepsis	yland Vet.  22. Name and Ad  Do not enter the mode of	Cem. 09-	07-04 C ustin Ro 821 14th	heltenha yster Fi	am, Md uneral Ho NW Wash
or complications that cause st only one cause on each  a	Sepsis as a conseque	Do not enter the mode of	3	821 14th		NW Wash Approximate
a. Due to (or a	Sepsis as a conseque		dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
bP						uays
b. Due to for a	Pneumo					days
<	as a conseque	nice of):				
c. Due to (or a	as a conseque	nce of):				
	2 Fetal de at time of deal	eath 3 Ectopic pregna			23d. Date of delive Month	very Day Year
tions contributing to death Decubit	ut not resulti Ulcer		e given in Part I.		co use contribute to	the cause of death?
Stroke					prior to co	opsy findings available ompletion of cause of
28a. Date of In (Month, D	njury 2	8b. Time of 28c. I	Injury at Work?			ify)
d not be 28e. Place of I	Injury - Al hom etc. (Specify)	e, farm, street, factory, off	fice			ral Route Number,
al Examiner: On the basis	s of examination	edge, death occurred at the and/or investigation, in n	ne lime, date and place, my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
ier		29c. Lio				. Day, Year)
a Mn			D32332	0	8-28-04	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Naomi Ρ. Howard 9:30 а.м /Medical 9 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Manor Care Balto If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 💢 F 76 Director ٧a 231-28-6277 11-22-1927 Usual Residence of Decedent death with the Maryland 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 27 is marked othar than "natural", or Itams 23a or 28a-f show traumatic evant, It's Modical Examinat must be notified at Director 1 ☑ Yes 2 ☐ No Md N/ABalto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2927 Oakley Avenue by Funeral 21215 US Α 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after of and Mental Hygiene.

is marked othar than "natural", or Itar Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black. 3 √Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of CT Medical Technician 8th grade N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Carpenter Estell Moody 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any injury or other traum once. Sybil Adams - Niece 4613 Belview Avenue Balto, Md 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Woodlawn Cemetery 9-11-2004 Balto, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 Yes SI No 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed' 1 ☐ Yes 25 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tyes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifie Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar SEP 0 9 2004

		1	For State	State of Maryl	· ·	ent of Health and ate of Death	-	_	-	
			Registrar  1. Decedent's Name (First, Middle, Las	t) ,	Certino	ale of Dealif	2. Date of De	Reg. No	<del>1004</del>	O C C T
	siciar edica		ISAAC W.	JO HINSON	JR		SEPT.	Oba	2000	1125AM
Exa	mine	r 4	IA. Facility Name (If not institution, give	Airin a mark on		ity, Town, or Location of Deat	h	4c.	N/A	
Fune Direct			5. Social Security Number  6. Security Number  1)  20 - 88 - 1078  1)  July 13 - 1078  1)  July 13 - 1078  1)	7. Age (In )	vrs. last birthday) If Ur Moni	nder 1 Year   If Under 24 Hrs hs Days Hours Min.		th Year	9. Birtho	lace (State or Foreign otry) Tyland
d 21215-0036 filed within 72 hours after death with the Maryland Hygiane. the then "natural", or items 23a or 28e-f show sht, the Medical Examinar must be notified at	3		10a. State 10b. County	100.	City, Town or Location	000			1	0d. Inside City Limits 1 ✓ Yes 2 □ No
with the la or 28e		יום ל	10e. Street and Number	1 01	101	Zip Code		10g. Cit	izen of What Cour	itry?
iter death		ulicia	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever i Armed Forces?		ecedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	Specify Yes or No to Rican, etc.)	)+r	14. Race - Americ Black, White,	
-0036 hours at trural, or	1 2 2		3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Ye	s 2 No Specify:		16h Ki	Specify: B	ack
Baltimore, Maryland 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In procrem: If item 27 is marked other then "natural", or items 23a or 28e-f show any nitury or other treumatic event, the Medical Espain en mast be routiled.	patalamo		(Specify only highest grade		(Give kind or	work done during most of wo. T use retired	rking	160. K	Privia-	La
nd h	0		17. Father's Name (First, Middle, Last)	- 1	a	18. Mother's Nar	ne (First, Middle,	Maiden	Sumame)	
arylan should be nd Mental marked o	F	2 .	LSAAC W. J 19a. Informant's Name/Relationship (7	ohnson	SC.	Phy	1115	<u> R</u>	rown	
e, Mar 1 and 2 sho Health and em 27 is m		1	Mrs. Phehe Je	ippo, Print) (wife)	3217	ess (Street and Number or Re		er, City o	r Town, State, Zip	21225
imore, Pages 1 a nent of He int: If item		2	20a. Method of Disposition  1 K Burial 2 Cremation 3		b. Place of Disposition ( cemetery, crematory		Date	20c. Lo	ocation - City or To	wn, State
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item any injury or other	di		<ul> <li>4 ☐ Donation 5 ☐ Other (Specify</li> <li>21. Signature of Funeral Service Licens</li> </ul>	)	1117, 2101	and Address of Facility	2004	La	nsdou	une, Md.
Dalti permit. Deporte Importe any nju	Suce		Desonk -	L. Kusi	Jose 2777	ph Kuss	Funer ve. Ba	al t	tom 21.	216
			23a. Pant I Enter the disease, or comp shoot, or heart fillure. List only of Immediate Cause (Final	lications that caused the done cause on each line.	eath. Do not enter the r	node of dying, such as cardiac	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
Physicia /Medic	al		disease or condition resulting in death)	aGM+ VFF Due to (or as a con:		Sax				3 months
Examin		5	Sequentially list conditions,	b. Smull lu	motionic te	kemia				Ayers
cuted nd	Fyaminer		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C						
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c 68 artificati ing phy as the		)	F FEMALE:	u						
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dS, P. uires that I signed by Id be deta	d by	F	Part II. Other significant conditions co	ntributing to death but not	resulting in the underlyir	g cause given in Part I.		obacco u res 2[	se contribute to th	3/
Records, he law requires t has been signe	2						24a. Was		24b. Were autop	esy findings available apletion of cause of
	S						perfor	med? 2 No	death?	2 No
VII 'sicie s certi	TO Be	1   [	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital: 1XInpatient 2	ER/Outpatient 3□	0+	th (Check only o			
ng Ph Ing Ph Iner th	-		27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year		28c. Injury at Work?	28d. Describe h		G □Other (Specify occurred	)
DIVISION  or Attending street death. I Director: After d in by the fune	Certification:		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, street, fac ecify)	tory, office	28f. Location (S City or Tow	Street and n, State)	d Number or Rural )	Route Number,
DIVISION OF VITA To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical		29a. Certifier (Check only one)  1 Cartifying Phy 2 Madical Exam	sician: To the best of my linar: On the basis of exam and manner stated.	knowledge, death occurrination and/or investigat	ed at the time, date and place ion, in my opinion, death occu	, and due to the c rred at the time, c	ause(s) date and	and manner as sta place, and due to	ited. the cause(s)
To ti Within To ti	M	2	29b. Signature and title of certifier	3D		29c. License number	2		e signed (Month, D	
4	2	3	30. Name and address of person who c	ompleted cause of death (I	tem 23a) (Type, Print) DO 22 5	GREENE ST, B	SALTUATRE			
	State istrar		31. Date filed (Month, Day, Year) SEP 0 9 20	32. Registrar's Si		backs	TO THE TOTAL	1	VXIV	1

			1 - For State Registrar	State of Mary		artment of H		_		00000
			Decedent's Name (First, Middle, Last	)		runcate or	Deatii	2. Date of De.	Reg. No.	3. Time of Death
	Physici /Media		John C1	ayton John	son			Septemb	Day	Year 7:06 PM
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Deat		4c. County	of Death
			Saint Asnes	Hospita		Balti	more		N/	A
	Funeral Director		21/-24-7452	x 7. Age (lr ☐M 2☐F 78	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird May 22	<sup>h</sup> 1926	9. Birthplace (State or Foreign Country) Mary Land
	and *		Usual Residence of Decedent  10a, State 10b, County	16	c. City, Town or Lo	nation				
	Aaryla f sho	5	MD Baltimo		Catons					10d. Inside City Limits 1 ☐ Yes 2 1 No
	the f	Director	10e. Street and Number		Odtons	10f. Zip Code			10g. Citizen of W	
	3a or		2117 Arlonne Dri	170			100	:		Ť
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever	r in U.S. 13.	Was Decedent of H		pecify Yes or No-	United 14. Race	- American Indian,
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ither than "natural", or items 23a or 28a-f show ont, the Medical Evartiest must be notified at	þ	1 ☐ Never Married 2 🏋 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 <b>∑</b> Yes 2 ☐ No If Yes, Give Year or Dates:		lf Yes, specify Cuba 1 □ Yes 2√1 No	an, Mexican, Puert  Specify:	o Rican, etc.)	Specify:	white, etc. White
20	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ication	16a. Dece	dent's Usual Occup	ation	17	16b. Kind of Bus	siness/Industry
2	thin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retired		king	Househo	ld Finance Corp
2	filed wi Hygien ther th	Son	12	0	Loan	n Manager				
Maryland	od is b ≥	To Be	17. Father's Name (First, Middle, Last) John Johnson	Sr.				ne (First, Middle, gia R. P	Maiden Sumame ickett	9)
ar	2 8 5 6		19a. Informant's Name/Relationship (T)	pe, Print)		ng Address (Street				
	of Heelth item 27 other tr		Michael Johnson	1		mmerfield	l Road, B		, MD. 21	1207
Baltimore,	0 0		20a. Method of Disposition 1 t Burial 2 ☐ Cremation 3 ☐ F		Ob. Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce)	Date		City or Town, State
≣	tmen tent: jury	-	` 4 Donation 5 □ Other (Specify)		Woodlawn	Cemetery				n, Maryland
Bal	permit, Page Department Importent; if any injury or once.		21. Signature of Funeral Service Licens	DNON MOC	333 8	/28 Liber	tv Road.	Randall	stown.MI	cal Directors 0. 21133-4784
			23a. Part. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the	death. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
4	Pnysician	8 11	Immediate Cause (Final disease or condition	Senci	•					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or saco	nsequence of):					Weeks
	Cxammer		Sequentially list conditions,	o. —						
	ed str	ine	if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):					
_	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
8/60	be e. ician buria	cai E		200 10 (01 20 2 00	nooquence ory.					
287	licate phys s the	edic		l						
Rox	leath certific attending p	√Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pr	regnancy				23d Date	of delivery
o.	that the death certifined by the attending detached for use as	Physician/M	in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Mont	
S,	requires that een signed b nould be deta	by Pr	Part II. Other significant conditions cor	stributing to death but no	ot resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
ras	v require been sig should be		End Stage R	enal Di	seuse.			1 □ Y	es 2 🗆 No 3	Probably 4.20nknown
Hecord	≥ .D. io	ompleted	Diahotos M	ellitus				24a. Was a	n 24b. W	ere autopsy findings available
	0 - 9	luo		201703				autops	mea?   ae	or to completion of cause of ath?
	ilcian: Th certificate rector, pag	e C	25. Was case referred to medical				26. Place of Dear			Yes 2□No
	di is	To B	examiner? 1 Tes 2 No	lospital:	2 ER/Outpatien	t 3 DOA Othe	or		ence 6 Other	(Specify)
	ding Pt h. After th funeral		27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injun Work			ow injury occurred	
SIO	Attending r death. sctor: After by the funer	catic	2 Accident investigation				Yes 2 □ No			
DIVISION	s after d	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, stre pecify)	eet, factory, office		28f. Location (Si City or Town	treet and Number n, State)	or Rural Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one)  12 Certifying Phys 2 Medical Examin	sician: To the best of my ner: On the basis of exa- and manner stated.	knowledge, death mination and/or inv	occurred at the tirr estigation, in my op	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and manr ate and place, an	ner as stated. d due to the cause(s)
	To th To th Comp	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (	Month, Day, Year)
	V		15	13	0=	P166	(40	•	Sont	ho. 00 0004
	10		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, I		11		CITON	1567 0 1) TOO 4
	W.			karan	900	Caton	Ave	Batti	nore	mp 21229
	Sta Registra	100	31. Date filed (Month, Day, Year) 9 2	004 32. Registrar's S	Signature	bode				

				epartment o Certificate o		fental Hygie	2001.	28559
	Physic		1. Decedent's Name <i>(First, Middle, Last)</i> Donald Ray	Joh	nson	2. Date of Death Septembe	Pay 6 2004	3. Time of Death 1:15PM M
	/Medi Examir		4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital		n, or Location of Death	_	4c. County of Death Prince G	1
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth $579-56-4285$ ${}^{1}\overline{X}^{M}$ ${}^{2}\Box$ F $59$ Yr	Months Da		8. Date of Birth (Month, Day, Ye May 3,19		nplace (State or Foreign untry) ington DC
	th the Maryland or 28a-f show	Irector	10e. Street and Number	np Spring	ie	10g.	Citizen of What Cou	
960	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, If w Marical Experiment was be realised at	by Funeral Director	5403 Henderson Way  11. Marital Status  1 □ Never Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 □ No 1965 ─ Year or Dates:  1967	13. Was Decedent If Yes, specify C	20746  of Hispanic Origin? (Sp. Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
Maryland 21215-0036		Completed by	15. Decedent's Education (Specify only highest grade completed)  [Specify (August (Aug	ecedent's Usual Oc Give kind of work do fe. DO NOT use re ephone Te			Kind of Business/li	
yland	12 should be filed within n and Mental Hygiene. r is marked other than "raumatic event, It e Ma	To Be (	17. Father's Name (First, Middle, Last) William Grafton Johnson		18. Mother's Name Nel	(First, Middle, Maig lie Rae W	hitmer	
3, Mar	and 2 sh lealth and m 27 is m				erson Way (		y or Town State, Zi gs, MD 20	p Code) 7 4 6
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau <u>once.</u>		1 □ Burial 2 □ Cremation 3 □ Removal from State cemetery,  '4 □ Donation 5 □ Other (Specify)  Lee C	isposition (Name of crematory or other rematory	place) Septer 2004	mber 12 C1	Location - City or T inton, Ma	ryland
Bal	Depar Depar Impor any in		21. Signature of Funeral Service Licenses	6633 01		a Ferry R	Carried Company	on, MD20735
	Prrysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Advanced Due to (or as a consequence of)  Sequentially list conditions.	n Lirh		or respiratory arrest,		Approximate Interval Between Onset and Death Unknown
8760,	rate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of)  c. Due to (or as a consequence of)					
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rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause	given in Part I.	23e. Did tobacci	use contribute to t	he cause of death?
Vital Records,		Completed				24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of
Division of Vita	Attending Physician: r death. ector: After this certific by the funeral director,	atlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  Hospital: 1 Impatient 2 ER/Outpa  27. Manner of Death 1 Matural 5 Pending investigation 28a. Date of Injury (Month, Day Year) 28b. Tim	e of 28c. In		(Check only one) ne 5 Residence 8d. Describe how in		(y)
building, etc. (Specify)					28f. Location (Street City or Town, Sta	and Number or Rura ite)	al Route Number,	
	To the Hospital or At within 24 hours after or To the Funeral Direc completely filled in by	Medical	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, d 2. Medical Examiner: On the basis of examination and/of and manner stated.	r investigation, in m	y opinion, death occurre	and due to the cause and at the time, date a	s) and manner as s nd place, and due to	tated. the cause(s)
þ	S com	Σ	29b. Signature and title of certifier  Roiter Full MD		D 43446		eate signed (Month, 9.7.04	
	10,		30. Name and address of person who completed cause of death (Item 23a) (Ty  ROLNTAN FARAHLEA MD 980 31. Date filed (Month, Day, Year) 2004  SEP 0 9 2004	pe, Print)	gia Are sui	+ 3-41 5	on spring	MOZOGOZ
	Sta Registr	te ar	31. Date filed (Month, Day, Year) 2004 32, 33, 39, 39, 31, 32, 33, 33, 33, 33, 33, 33, 33, 33, 33		)			

			1 - For State Registrar	State of	f Maryland / I	-	rtment o			and M	lental Hy	giene	1001	20566	7
		w <sup>y</sup>	Decedent's Name (First, Middle, Last	st)							2. Date of De	ath		3. Time of Death	-
	Physici /Medio		JOHN ARTHUR JUB	В							Month SEPTEM	Day IBER	y Year 6, 2004	2:40 P.	М
	Examir		4a. Facility Name (If not institution, give	street and nur	nber)		4b. City, Tow	n, or L	ocation o	of Death			County of Deat		·
			MARINER HEALTH C						T HI				HARFORI	)	
	Funeral		5. Social Security Number 6. S	ex GM 2□F	7. Age (In yrs. last bi	irthday) _ Yrs.	If Under 1 Ye Months Da		Hours	Min.	8. Date of Bi (Month, D	ay, Year)	9. Birt	hplace (State or Fore	ign
	Director		217-26-0473 Usual Residence of Decedent		74	113.					May 12	, 19:	30 Ma	ryland	_
	yland yland		10a. State 10b. County		10c. City, Tow	wn or Loc	ation							10d. Inside City Limi	ts
	a-f sl	ctor	Maryland Harfo	ord	For	est	Hill							1 □ Yes 2,√2,1	lo
	or 28	Director	10e. Street and Number				10f. Zip Cod	le				10g. Citi	izen of What Co	untry?	
	ba filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itams 23e or 28e-f show other than "natural", or Itams 25e or 28e-f show event, I've Medical Examérat must be rodified at		112 Gwen Drive	Condo	G			210	50				USA		
	Br de	Funeral	11. Marital Status	Armed Fo		13. W	Vas Decedent Yes, specify C	of Hisp Cuban,	anic Orig	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	o-	<ol> <li>Race - Ame Black, White</li> </ol>		
36	rs aft	by F	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes If Yes, Giv Year or Da	9	1	□Yes 2 <b>∑</b> t	No .	Specify:				Specify:		
21215-0036	tural	ed t	15. Decedent's Ed			Deced	ent's Usual Oc	cupatio	on			16h Ki	M nd of Business/	nite	
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212	d within giene. ir than *	mo	9	College (1		re M	aintena	ance	e Te	chni	cian	Tel	ephone.	Utility Co	٥.
9	ba filled tal Hygid d othar evant, L	Bec	17. Father's Name (First, Middle, Last)					18	8. Mothe	r's Name	(First, Middle	-			
/lai	should b and Ments marked	To	Gordon Paul J	ubb					Eli	zabe <sup>.</sup>	th Pea	arl	Philips		
Maryland	C1 00 - 10 00	. 5	19a. Informant's Name/Relationship (7	, ,	196	b. Mailing	Address (Str	eet and	d Numbe	r or Rura	l Route Numb	er, City o	r Town, State, Z	ip Code)	
	1 and Health tam 27 othar tr		Elaine Jubb / Wi	fe					Fore		Hill, N				
Baltimore,	Pages 1 nent of H int: If ita iry or otl		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from S	nom oto	of Dispos ery, crem	ition (Name of atory or other	place)	i	С	ate	20c. Lo	cation - City or	Town, State	
Ë		١,	4 □ Donation 5 □ Other (Specify		Bel A	ir M	emoria]	L Gr	rdn's	9-9	9-04	Ве	l Air,	Maryland	
Bal	permit. Departr Importa any inju		21. Signature of Funeral Service Licen	588	- NA AL-CARAGO						ome, P.				
	*		23a. Part 1. Enter the disease, or comp	- Jean	audad the death. De	201 0010	50 W. E	3roa	adway	<b>∠,</b> Be	el Air,	Mar	yland 2		
		ļ	23a. Part1. Enter the disease, or comp shock, or beart failure. List only Immediate Cause (Final	one cause on ea	ach line.							rrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. ne	lastal		Blu	20	a c	elle	·v				
	Examiner			Due to (	or as a consequence	of):									
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Uue to (	ог ве в сопевциенов	uf):									
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	2											
o	an an rial-tr	Exa	resulting in death) Last	Due to (	or as a consequence	of):									
8760,	cate be executed physician and the burial-transit	dlcal		d											
9	ing ph	Med	IF FEMALE:				100 m (s. 100 m)	_			-				
Вох	death certific e attending p id for use as f	Physician/Me	23b. Was decedent pregnant in the past 12 months?		come of pregnancy irth 2  Fetal death		Ectopic pregna					2	3d. Date of deli	•	
0	0 0 0	/sic	1 Yes 2 No	4□Pregna 9□Unkno	ant at time of death	5 🗌	Other (specify,						Month	Day Year	
Δ.	law requires that the das been signed by the 2 should be detached		Part II. Other significant conditions co	ontributing to de	ath but not resulting in	in the un	derlying cause	alven i	in Part I		23e Did t	obacco u	se contribute to	the cause of death?	
ds,	signe signe	d by	Tall the state of	onthouring to do	att but not rosulting in	in the dire	derlying cause	giveiri	iii rai(i.			Yes 2[		bably 4- Unknow	m
Sor	w requir been si should	ete									-				
Records,	9 - 9	Completed									24a. Was autor perfo			opsy findings available ompletion of cause of	
_		e Co	25. Was case referred to predical						a Bi	10 1	1 Yes_			2 No	
		o B	examiner?	Hospital:	npatient 2 ER/Ou	utnationt	3□ DOA	Other:		-	Check on		☐Other (Spec	24.1	-
	g Phys er this eral di	$\vdash$	27. Manner of Death	28a. Date of	f Injury 28b.	Time of	28c. lr	njury at			8d. Describe l			iry)	_
io	Attanding r death. actor: After by the funer	atlo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		h, Day Year) I	Injury		Vark?	s 2 🗆 N	io					
Division	r Attan er deat ractor: by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	286. Place	of Injury - At home, fa ng, etc. <i>(Specify)</i>	arm, stre	et, factory, offic	00		2	8f. Location (S City or Tox	Street and	d Number or Rui	ral Route Number,	
	ital or rs aft ral Di	Cer									0.17 0.1 7.01	m, olaloj			
	Hospi 4 hou Funar ely fill	edical	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exam	sician: To the	best of my knowledge sis of examination an	e, death	occurred at the	time,	date and	l place, a	nd due to the	cause(s)	and manner as	stated.	
	To tha Hospital or Attanding I within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	Medi	one)	and mann	er stated.										
	To Wit	<	29b. Signature and title of certifier				29c. Lice	ense ni	umoer				signed (Month		
7	7		1 Vont 3	12m				3	22	-75		30	b2 3	204	
	(0)		30. Name and address of person who o				,	ייבור כד	т Ат	D 14	D 014	21/			
	Sta	te	DR. DAVID DUNN - 31. Date filed (Month, Day, Year)		V. MacPHAI			BE	L AI	к, М	υ <b>.</b> 210	014			
	Registr		SEP 0 9 200	14	egistrar's Signature	400	als.								

		1 - State Registrar	tate of Maryland	l / Depa		lealth and	Mental Hyg	ag. No. () () [	28561
Physic /Med		Decedent's Name (First, Middle, Last)	Cynthia	Jones			2. Date of Deat Month Septemb	/ Day Year	3. Time of Death 4 230p M
Exami		4a. Facility Name (If not institution, give street)	reral Hop	Hal.	Baltim	or Location of Deal	144		N/A
Funeral Director	1	5. Social Securify Number 6. Sex 217-58-8515  Usual Residence of Decedent	7. Age (In yrs. ia 247	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 9. B 1960	nthplace (State or Foreign Country) Maryland
Maryland -1 show	tor	10a. State 10b. County  Maryland N/A	10c. City,	Town or Lo		altimore			10d. Inside City Limits 1 ∑ Yes 2 □ No
with the 3e or 28e	Funeral Director	10e. Street and Number 264 S. Loudon Ave			10f. Zip Code	21229	1	0g. Citizen of What C	Country?
<b>Baltimore, Maryland ZIZI3-UU30</b> permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 271s marked other than "natural, or Items 23e or 28e-f show any injury or other treumatic event, it is Madical Examinant temptified at 000es.	b	1 ☑ Never Married 2 ☐ Married	Mas Decedent Ever in U.S Armed Forces? I ∐Yes 2 ⊠No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub		Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh Specify:	
Z1Z15-UU36 d within 72 hours aff giene. sr then "natural", or	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done durn life. DO NOT use retired)  Home			pation during most of wo d) nemaker	uring most of working		s/Industry ome	
land A	To Be C	17. Father's Name (First, Middle, Last)  Eldridge Jo	ones			18. Mother's Na	me (First, Middle, M Shirle	Maiden Sumame) ey Jackson	
Mary and 2 shore alth and No. 27 Is ma		19a. informant's Name/Relationship ( <i>Type</i> , Shirley Jackson Mother	Print)		_		ural Route Number, ore, Maryland	City or Town, State, 21229	Zip Code)
Baltimore, Maryland bernit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: If item 27 is marked oth any injury or other freumatic event once.		20a. Method of Disposition  1 ဩ Burial 2 ☐ Cremation 3 ☐ Remo  4 ☐ Donation 5 ☐ Other (Specify)	COL	metery, crei	osition (Name of matory or other pla Loudon Park	сө)	Date 2	20c. Location - City o Baltim	r Town, State ore, MD
Dermit. Departr Importe any inji		21. Signal of Fund Service licensee	4	S	2. Name and Addre Estep E 1300 E	Brothers Funutaw Place	eral Home P./ Baltimore, MD	Δ. ) 21217	
ate be executed  ate be executed  Examine burial-transit  by sician and  the burial-transit	ical Examiner	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one commendate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causs. Little United by the Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a conseque	ence of):	ter the mode or dyll	ng, such as cardia	c or respiratory arre	sst,	Approximate Interval Between Onset and Death
S, F.O. BOX 68 es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	in the past 12 months?	If yes, outcome of pregnan 1□Live birth 2 □ Fetal of 4□Pregnant at time of dea 9□Unknown	death 3	□Ectopic pregnanc □ Other (specify) _	у	2 - 2 - 2-102	23d. Date of do Month	elivery Day Year
Records, P.O. The law requires that the tee has been signed by the tage?	þ	Part II. Other significant conditions contrib	uting to death but not resul	ting in the u	inderlying cause giv	ven in Part I.			to the cause of death?  Probably 4 X known
	Completed							ned2 death? No 1 ☐ Ye	
ag Phys ter this	atlon; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of D ath 1  Hatural 5 Pending investigation	1 Minpatient 2 LE	R/Outpatier 28b. Time o Injury	of 28c. Inju.	ner: 4 Nursing I	_	e) ance 6 □Other (Sp aw injury occurred	ecify)
DIVISION of or Attending s after death. I Director: After	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	8e. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	reet, factory, office		28f. Location (St. City or Town	reet and Number or F i, State)	Rural Route Number,
To the Hospitel or Attending guithin 24 hours after death.  To the Funerel Director: After Completely filled in by the fune.	edical (	29a. Certifier (Check only one)	an: To the best of my know On the basis of examination and manner stated.	rledge, deat on and/or in	vestigation, in my	opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
yer	X	29b. Signature and title of certifier	ll		29c. Licens	9541	′	9d. Date signed (Mor	nth, Day, Year)
		30. Name and address of person who comp	7 M.D.	90	Print) Mary	1 knd	Genera	el Hos	oi tal
S Regis	tate trar	31. Date filed (Month, Day, Year) SEP 0 9 2004	32. Registrar's Signatu	A A	Spores	,		/	

UNKNOWN 04-292

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

OTALGAMIA	04-
04-5595	

DOS	1 - State Amend Item #26 Registrar  1. Decedent's Name (First, Middle, Last)	1-	Centricate of Death	2. Date of De		14 1225.52
Physician /Medical	Antonio	С.	Jackson	Month	Day	Year 1505 p
Examiner	4a. Facility Name (If not institution, give st. 3706 West Belvede		4b. City, Town, or Location of De Baltimore	ath	4c. County of	of Death
Funeral Director	5. Social Security Number 6. Sex N/A	7. Age (In yrs. last b	rithday) If Under 1 Year If Under 24 H Months Days Hours Mi	n. (Month, Da	th ay, Year)	9. Birthplace (State or Foreig Country)  MD
ene. than "natural", or items 23e or 28e-f show the Madical Exercites be notified at ompieted by Funeral Director	Usual Residence of Decedent  10a. State 10b. County	10c City To	vn or Location			
f show	MD NA		imore			10d. Inside City Limit XXYes 2 ☐ N
be natified Director	10e. Street and Number		10f. Zip Code		10g. Citizen of W	hat Country?
23a c	3613 Hayward Av	e	21215		U.S	• A •
al, or tiems 23a or 28a-f shores and Examiner must be notified at Examiner must be notified at by Funeral Director	11. Marital Status  1X Never Married 2  Married  3  Widowed 4  Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 VVo If Yes, Give	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put  1 ☐ Yes 2 [X No Specify:	(Specify Yes or No erto Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. Black
	15. Decedent's Educa (Specify only highest grade	Year or Dates:  ation 16a completed)	Decedent's Usual Occupation     (Give kind of work done during most of w	rodkina	16b. Kind of Bus	DIGCK
mp id	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)	life. DO NOT use retired)  Laborer	o.n.n.g	Various	s Jobs
d other event, Be C	17. Father's Name (First, Middle, Last)			ame (First, Middle,		
arked etic e	Robert Lee Jack		Brenda			
T is marked other treumetic event. II	19a. Informant's Name/Relationship (Type		o. Mailing Address <i>(Street and Number or I</i> 3613 Hayward Ave			
item 27 i	20a. Method of Disposition	20b. Place	of Disposition (Name of	Date		City or Town, State
nt: If i	X Burial 2 ☐ Cremation 3 ☐ Re  14 ☐ Donation 5 ☐ Other (Specify)	moval from State	ory, crematory or other place)  Carmel Cemetery	77/04		ore, Md
Department of He Importent: If iten any injury or oth once.	21. Signature of Funeral Service Licensee		March F/H West 4300 Wabash Ave	_		
ysician ledical aminer ច្ច	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Cirrhosis of t  Due to (or as a consequence	of):	as or respiratory at	11631,	Approximate Interval Between Onset and Death
by physician and as the burial-transit	that initiated events c. resulting in death) Last	Due to (or as a consequence	of):			
ed by the attending detached for use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date Mont	of delivery h Day Year
be o	Part II. Other significant conditions contri	ibuting to death but not resulting	in the underlying cause given in Part I.			oute to the cause of death?
E 9 E					nsv pri	ere autopsy findings available or to completion of cause of attr?
certificate rector, pag	25. Was case referred to medical examiner?		26. Place of De	eath (Check only o		
sid in D	1X Yes 2 ☐ No  27. Manner of Death	spital: 1 Inpatient 2 ER/O				(Specify) at scene
tor: After this certific the funeral director, cation; To Be (	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Time of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe f	now injury occurred	1
Direct In by	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f. Location (S City or Tow	Street and Number vn, State)	or Rural Route Number,
within 24 hours after of To the Funerel Direct completely filled in by Medical Certifi	29a. Certifier (Check only one)  1 Certifying Physic 2 Medical Examine	cian: To the best of my knowledger: On the basis of examination and manner stated.	e, death occurred at the time, date and plac d/or investigation, in my opinion, death occ	ce, and due to the courred at the time, of	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
To the comp	29b. Signature and title of certifier	ris-Pollo	29c. License number OCME	4		Month, Day, Year) 2004
State	30. Name and address of person who com 31. Date filed (Month, Day, Year)	pleted cause of death (Item 23a)  A - CA -	(Type, Print)  HD 111 Penn Stree	et, Balti	more, Mai	ryland 21201

State Registrar

SEP 0 8 2004

32. Registrar's Signature

Paul Kirby

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

	04-0571 RPD	0	1 - For State Registrar	State of Maryla		artment of I			0001	00560
	Physici /Medic		1. Decedent's Name (First, Middle, La Paul Charles	Kirby, Jr.				2. Date of Dea Month Septem	ber <sup>Day</sup> 4, 200	
}	Examin	er	4a. Facility Name (If not institution, giv University Hospi	tal		Baltimo			4c. County of De	ath
	Funeral Director		5. Social Security Number 6. Sunknown  Usual Residence of Decedent	Sex 7. Age (In yi	rs. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	<sup>h</sup> <sub>v, Year)</sub> 9. B 26, 1985 N	irthplace (State or Foreign Country) Iaryland
	Maryland -f show	tor	10a. State 10b. County Maryland N/A		City, Town or Lo Balti					10d. Inside City Limits 1√2 Yes 2 ☐ No
	h with the	al Director	10e. Street and Number 206 S. Smallwo	ood Street		10f. Zip Code 2122	3		10g. Citizen of What (	Country?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28e-f show any injury or other treumatic event, Ite Medical Examinar must be rediffed at once.	by Funerai	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:		Was Decedent of his yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:B1	
21215-0	od within 72 ho giene. er than "natu	Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12) 11th grade 17. Father's Name (First, Middle, Last,	ade completed)  College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of work d)	ing	16b. Kind of Busines High Sch	
Maryland 2121	should be filed vind Mental Hygie marked other i	To Be (	17. Father's Name (First, Middle, Last, Paul C. Kirby,				Bedelia	Damon		
, Mar	and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (Paul C. Kirby,	Sr./ Fathe	er 206	S. Sma	llwood S	Street		e, Md21223
Baltimore,	t. Pages 1 rtment of H rtent: If ite		20a. Method of Disposition  ↓ Burial 2 Cremation 3 C  `4 Donation 5 Other (Specif		t. Zion	n Cemet	ery 9/1	4/04 B	altimore	, Maryland
Ball	permit Depart Import any in		21. Signature of Funeral Servin Licer		52	Name and Address 240 Reis	sterstow	atman- n Rd B	Harris F altimore	uneral Hom ,Md 21215
	Physician /Medical Examiner		Z3a. Party. Enter the disease, or com- spock, or heart failure. List only Imprediate Cause (Final risease or condition resulting in death)	plications that caused the de one cause on each line.  a					rest,	Approximate Interval Between Onset and Death
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury	b. — Due to (or as a cons	equence of):					
8760,	death certificate be executed e attending physician and of for use as the burial-transit		that initiated events resulting in death) Last	consequence of):						
P.O. Box 6		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy	/	11 1000	23d. Date of do Month	I Blivery Day Year
ecords, F	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but not r	esulting in the ur	nderlying cause giv	en in Part I.		bacco use contribute es 2⅓ No 3 ☐ F	to the cause of death?  Probably 4 Unknown
Vital Heco	The ate h page	Completed						24a. Was a autops perfor	sy prior to	utopsy findings available completion of cause of s
or Vita	Physicien: The this certificate had director, page	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	[XER/Outpatien	t 3 DOA	26. Place of Deather: 4 Nursing Ho		ence 6 Other (Sp.	ecify)
Division	ding I	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	e 29a Place of Injuny - At	2:45	/ )	Yes 2 □Xio	Subje	ow injury occurred  the add of the stand of	
2	i in it o		4 Schomicide determined  29a. Certifier 1 Certifying Ph	vsician: To the best of my k	Sheet	occurred at the tir	ne date and place	1800 W	Prztst Be	thmore, MD
	To the Hospitel within 24 hours a To the Funerel I completely filled	<b>Aedical</b>	one) 2 Medical Exar	niner: On the basis of exami and manner stated.	nation and/or inv	estigation, in my d	pinion, death occurr	ed at the time, d	ate and place, and du	e to the cause(s)
<b>-</b>	5 With 20	×	29b. Signature and title of certifier  Joshan	Treentres	MO	O.C.			9d. Date signed (Mon September 4	
			30. Name and address of person who	completed cause of dith (It			Street B	altimore	Marrylany	3 21201

State Registrar

Tasha Zurelnherz M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature SEP 0 9 2004

			1 - State of I		artment of Health and M rtificate of Death		ene 2.004 2	8564
	Physici		1. Decedent's Name (First, Middle, Last) Jessie	Jeanette	Keller	2. Date of Death Month September	Day Year	3. Time of Death  1:00 P <sup>M</sup>
	/Medio Examir		4a. Facility Name (If not institution, give street and number E.F.D. Personal Care, In	c.	4b. City, Town, or Location of Death		4c. County of Death Cecil Co.	
	Funeral Director		5. Social Security Number  213-16-4500  Usual Residence of Decedent  7. □ M 27 F	Age (In yrs. last birthday)  86  Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y Aug. 19		lace (State or Foreign try) Yland
	e Maryland Be-f show	Director	10a. State 10b. County Maryland Cecil Co.	10c. City, Town or Lo	cation		10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with th		10e. Street and Number 88 Macintosh Drive		10f. Zip Code	1917	Citizen of What Coun United Sta	,
9036	within 72 hours after death with the Maryland gne. than "natural", or Items 23a or 28e-f show the Michael Examinat mat be invitified at	i by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  1 □ Yes 2 □ Yes 2 □ Yes or Date	s? ∃ <b>A</b> No	Was Decedent of Hispanic Origin? (Sp. ff Yes, specify Cuban, Mexican, Puerro     □ Yes 2		14. Race - America Black, White, & Specify:	an Indian,
Maryland 21215-0036	P1 20 30 800	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4c)	(Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired) ICK Dispather	ing	b. Kind of Business/Ind Steel Indu	lustry
/land 2	ss 1 an of Heal litem 2	To Be (	17. Father's Name <i>(First, Middle, Last)</i> Walter Kowalczyk		18. Mother's Nam Mary	e (First, Middle, Ma.	iden Sumame)	
			19a. Informant's Name/Relationship (Type, Print) Kathleen Zamenski (Daugh	ter) 88		a <i>l R</i> oute Number, C Colora, M		<sup>Code)</sup> 1917
Baltimore,			20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from Sta  4 ☐ Donation 5 ☐ Other (Specify)		sition (Name of natory or other place)  Service Corp. 9/1		c. Location - City or Tov Towson, Mai	
Balt	permit. Page Department Importent: fi any injury o		21. Signature of Funeral Service Licensee	22 I	Name and Address of Facility Ouda-Ruck Funeral 1922 Wise Ave. Du	Home of D	undalk, In	
>	Physician /Medical Examiner	ler	Sequentially list conditions.		er the mode of dying, such as cardiac  Cardio Vas CVII			Approximate Interval Between Onset and Death
. 68760,	death certificate be executed e attending physician and id for use as the burial-transit	Aedicai Examine	that initiated events resulting in death) Last  Due to (or an event of the control of the contro	as a consequence of):				
.O. Box		Physician/Me		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)	·	23d. Date of deliver Month	y Day Year
<u>α</u>	w requires that the been signed by th should be detache	by	Part II. Other significent conditions contributing to death HENEYE	but not resulting in the ur	nderlying cause given in Part I.		co use contribute to the	e cause of death?
Division of Vital Records,	The law ate has t page 2 s	Completed				24a. Was an autopsy performed 1 ☐ Yes 2 ☑	prior to com death?	sy findings available pletion of cause of
f Vit	g : 5	To Be	25. Was case referred to medical examiner?  1 Yes 2 1 Yo Hospital: 1 Inpa	tient 2 ER/Outpatien	Othor	n <i>(Ch</i> eck only one) me 5 ☐ Residence	e 6 Dother (Specify)	core
ision c	Jing After funer	Certification;	27. Mannar of Death  1 Alatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	H	Work? M 1 Yes 2 No	28d. Describe how i	injury occurred  t and Number or Rural	Davida Alicente
Ö	Hospital or Attend 24 hours after death Funeral Director: stely filled in by the		4 Homicide building,	Injury - At home, farm, streetc. (Specify)		City or Town, S	itate)	
	To the Hos within 24 ho To the Fun completely	Medical	29a. Certifier (Check only one)  1 Concine Section 1 Check only one)  1 Concine Section 1 Check only one)  1 Concine Section 1 Concine Section 1 Check only one)  2 Section 1 Concine Section 1 Check only one)  2 Section 1 Concine Section 1 Check only one)  2 Section 1 Check only one)  3 Section 1 Check only one)  4 Section 1 Check only one)  4 Section 1 Check only one)  4 Section 1 Check only one)  5 Section 1 Check only one)  5 Section 1 Check only one)  6 Section 1 Check only one)  6 Section 1 Check only one)  7 Section 1 Check only one)  7 Section 1 Check only one)  8 Section 1 Check only one)  8 Section 1 Check only one)  9 Section 1 Check only one)  9 Section 1 Check only one)  1 Section 1 Check only one)  2 Section 1 Check only one)  2 Section 1 Check only one)  3 Section 1 Check only one)  4 Section 1 Check only one)  4 Section 1 Check only one)  5 Section 1 Check only one)  6 Section 1 Check only one)  1 Section 1 Check only one)  1 Section 1 Check only one)  1 Section 1 Check only one)  2 Section 1 Check only one)  2 Section 1 Check only one)  3 Section 1 Check only one)  4 Section 1 Check only one)  5 Section 1 Check only one)  6 Section 1 Check only one)  7 Section 1 Check only one)	of examination and/or inv	restigation, in my opinion, death occurr	ed at the time, date	and place, and due to t	the cause(s)
	on Vitt	1	I How Cott Jack	ron, Ml.	020993		9.7.04	
1	710		30. Name and address of person who completed cause of Howlett Jackson /	death (Kem 23a) (Type,	5. union Ave	- Haure	De Grace	= MD
	Sta Registr		31. Date filed (Month, Day, Year)	strar's Signature	de		21	018

			1_ State	Department of Health and M	lental Hygie	ne
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. 2. Date of Death	N6. UU4 20000
	Physici		James Kirslow			Day 2004 1715 PM
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		•	NORTH ARUNOEL HOSPITAL	L GLENBURN	IE	ANNEARLINDEL CO.
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs, last bi	inthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign
Н	Director		Usual Residence of Decedent	Yrs.	DEC. 15,1	1944 NEW JERSEY
	yland sow		10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
	Mar a-f st	ctor	MARVLAND ANNE ARUNOEL	ODENTOI	V	1 ☐ Yes 2√2 No
	or 28	Olre	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	death with the Maryland ms 23a or 28a-f show Fittual be rediffed at	rall	1318 HUNTOVER DRIVE			USA.
	after death with the Marylan or frams 23a or 28a-f show transf.mast.ce.rudffled at	Funeral Director	11. Marital Status  1□ Never Married  12. Was Decedent Ever in U.S. Armed Forces?  1□ Never Married  2□ Married	<ol> <li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
980		by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify 34ACV
21215-0036	be filed within 72 hours after ital Hygiene. Ind othar than "natural", or fta avant, the Medical Exartina	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work)	16b	. Kind of Business/Industry
121	vithin ne. han	mp	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of workillife. DO NOT use retired)		2/2 2 12 17
5	e filed within al Hygiene. other than " vant, the Me		17. Father's Name (First, Middle, Last)	NSURANCE AGE	(First, Middle, Maid	INSURANCE COE
aŭ	ld be ental kad o	To Be		SLOW MAR		SUMMERS
Maryland	2 should by and Menta Is markad aumatic ay	-		o. Mailing Address (Street and Number or Rura		
	and 2 ealth a n 27 I		DOREATHA L. KINSLOW (WIFE) K	318 HUNTOVER DR.	DENTON	1,MD. 21113
Baltimore	Pages 1 and 2 should tent of Health and Mer nt: if itam 27 is marks iry or other traumatic					
Ē	Pa men ant: ury		'4 □ Donation 5 □ Other (Specify)  BRIG. GEN	WM. C. DOYLEVA. CEME. U9-1	3-04 W	RIGHTS TOWN, NJ.
Ba	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	WM C. DOVLE VA CEME, 09-1 22. Name and Address of Facility BA	gown Ji	K. F-UNERAL HOME
	_		23a. Part I. Enter the disease, or complications that caused the death. Do	not enter the mode of dying, such as cardiac of	r respiratory arrest.	Approximate
	Pnysician		shock, or heart failure. List only one cause on each line.	huno cancer		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a.   Due to (or as a consequence	000 4		/3 mo
	Examiner		Sequentially list conditions, b.			
	pe tis	Examiner	if any, leading to immediate Due to (or as a consequence cause. Enter Inderlying Cause (Disease or injury	of):		
•	xecut and al-tran	хап	that initiated events resulting in death) Last  C. Due to (or as a consequence	of):		
8760,	cate be executed obysician and the burial-transit	dlcalE	d			
9	tificat ng phy as th	ledi				
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1	3 DEctopic pregnancy		23d. Date of delivery
о. Ш	ie dea the at hed fo	Physician/Me	in the past 12 months?  1  Yes 2 No 9  Unknown  1  Unknown	5 Other (specify)		Month Day Year
<u>α</u>	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Phy	Part II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Part I	23e. Did tobacci	o use contribute to the cause of death?
Vital Records,	uires tha signed Id be del	d by	pulmonary emboli	and and any ing database given are a care.		2 □ No 3 Probably 4 □Unknown
COL	w requir s been si should I	lete	type 2 diapotes		24a. Was an	24b. Were autopsy findings available
Re	ician: The lav certificate has ector, page 2	Completed	The courtes		autopsy performed?	prior to completion of cause of death?
ita		Be C	25. Was case referred to medical	26. Place of Death	1 ☐ Yes 2 € 1 Check on one	No 1 ☐ Yes 2 ☐ No
	S S	To E	examiner? 1 Tyes 2 No Hospital: 1 Inpatient 2 ER/OL	Other		6 ☐Other (Specify)
Division of	ling P	iuo]	1 Natural 5 ☐ Pending (Month, Day Year)	njury Work?	8d. Describe how in	jury occurred
Sic	ofeath death ctor: A y the fu	licat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home fa	M 1 Yes 2 No	18f Location (Street	and Number or Rural Route Number,
<u>S</u>	after after I Dire	Certification:	4 Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specity)	mi, street, lactory, office	City or Town, Sta	are)
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funaral Director: After this certific completely filled in by the funeral director,		29a. Certifier Certifying Physician: To the best of my knowledge	a, death occurred at the time, date and place, a	nd due to the cause	(s) and manner as stated.
	tha Ho lin 24 tha Fu	Medical	(Check only 2 Medical Examiner: On the basis of examination an and manner stated.			
ı	Vith To To To	2	29b. Signature and title of certifier  WWWWWWWWW	29c. License number	29d. E	Date signed (Month, Day, Year)
•			VUVUIVUY VVV	174804		11 1/00/
	HYIVE		30. Name and address of person who completed cause of death (Item 23a)  KANN M DAAL MD XV 28 KM	(Type Print)  A South	1 Paran	eva MB 4/27
	Sta	tę	31. Date filed (Month, Day, Year)  32. Registrar's Signature		, , , , , ,	
	Registr		SEP 0 9 2004 Deneva	& South		

State of Maryland / Department of Health and Mental Hygiene For State RegistreenD ITEM #26 PER PHY G835 9/09/04/5H 1. Decedent's Name (First, Middle, Last) **Physician** DOROTHY LUNES /Medical 4a. Fecility Name (If not institution, give street and number) Examiner

29d. Date signed (Month, Day, Year)

Year

**Funeral** Director

filed within 72 hours after death with the Maryland r than "natural", or items 23s or 28e-f show the Medical Examiner must be notified at other than and Mental permit. Pages 1 and 2 should be Department of Health and Mental Importent: If 1em 27 Is marked any Injury or other traumatic evonant.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

ng physician and as the burial-transit or Attending Physicien: The law requires that the death certificate be executed certificate the Director: filled in by within 24 hours a

Division of Vital Records,

2. Date of Death Month 5:55 PMM 3, 2004 September 4b. City, Town, or Location of Death 4c. County of Death Phoenix Baltimore 16160 Old York Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 □XF 83 Yrs. Illinois 334-18-0588 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Joppa Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21085 421 Latimer Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Furniture Manufacturing Executive Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry Augustus Wolf Edna May Ritter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David Kunes - Son 636 Cider Press Loop, Joppa, Maryland, 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Pauls Luth Ch Cem Sept. 9 2004 Kingsville, Maryland 5 Other (Specify) Service Licensee 21. Signa 22. Name and Address of Facility McComas Funeral Home 1317 Cokesbury Rd., Abingdon, Maryland 21009 fair. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestine facture ~ 18 marthe Due for as a consequence of): pertue Due to I fr as a consequence of): Sequentially list conditions, Examiner if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnap 3 DEctopic pregnancy in the past 12 month 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 Tyes 4 Unknown stasio ulcees Completed 24b Were autopsy findings available prior to completion of ause of death?
1 ☐ Yes 2 ☐ No 24a Wasan 2 PNo 1 Yes Be 25. Was case referred to medical 26. Place of Leath Check only one DAUXHTER 's examiner? 4 Nursing Home 5 Residence 6 X her (Specify) RESIDENCE ٩ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Mann of Death 1 Matural 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 29b. Signature

31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item



3a) (Type, Print)

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Year Kenneth Kelly September 3,2004 Sr. 9 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3502 E. Fairmount Avenue Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Fountry) | Days | Hours | Min. | Jan. 27, 1935 | Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 → M 2 □ F 69 Director 215 30 1988 Yrs. Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23a or 28a-f ahow other traumatic event, the McJical Eyanin ethnist be nutliked at Director 1 Yes 2 □ No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3502 E. Fairmount Avenue 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7. In and Mental Hygiene. 7 is marked other then "n. Elementary/Secondary (0-12) College (1-4or 5+) Fabricator 9 Sheet Metal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond Kelly Emma Harr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: if item 27 ien eny injury or other traum LaVerne Metzger (Daughter) 418 Crisfield Rd. Middle River, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 9/9/2004 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Structure of Fineral Service 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave. Essex, Part 1. Enter the disease, shock, or heart failure. 21221 ins that cause if the death. Do not enter the mode of dying, such as cardiac or ry piratory arrest, luse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final e Physician disease or condition resulting in death) 1 Cm secinds /Medical Due to (or as a equence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine use as the burial-transit The law requires that the death certificate be executed V that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Box 68760, Physician/Medical ension IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🖄 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Alatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours, the Funeral Director Silvers of the filled in " 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D15408 30. Name and address of person w o completed cause of dea / (Item 23a) (Type, Print) · macoonald 2801 Hudson Street Baltimore, Md 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 0 9 2004 Registrar

			1 - State Registrar	epartment of Health and Me Certificate of Death	Reg	ne No. 1 1 1	28558	
	Physici	an	1. Decedent's Name (First, Middle, Last)	2	. Date of Death Month	Day Year	3. Time of Death	
	/Medio	al	Kathleen M. Kane		EPTEMBER			
	Examir	er	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center	4b. City, Town, or Location of Death			t timore	
	Funeral Director		5. Social Security Number  219-44-5089  G. Sex  1 M 2 K F  7. Age (In yrs. last birtho	fay) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min. Ni	Date of Birth (Month, Day, Ye	9. Birl 946 Mai	thplace (State or Foreign cyland	
	/land		10a. State 10b. County 10c. City, Town o	r Location			10d. Inside City Limits	
	Many P-f sh	to	Md. Baltimore Towson				1 ☐ Yes 2X € No	
	th the	irec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	ountry?	
	23a c	Funeral Director	8216 Thorton Road	21 204		USA	Ą	
	tems er m	nei	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ric</li> </ol>	y Yes or No-	14. Race - Ame Black, Whit		
36	s afte	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		0 "		
8	turel	ed t		ecedent's Usual Occupation	1.00	. Kind of Business/	nite	
715	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28e-f show I's Modical Exercirer must be notified at	piet	(Specify only highest grade completed) (G	ive kind of work done during most of working to DO NOT use retired)	TOL	. Kind of business	muustry	
212	d with giene gritha	Completed	Elementary/Secondary (0·12) College (1·4or 5+) +2 EXE	ecutive Secretary		Shippi	ing	
p	al Hy d other	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name (F		,		
Уa	ould the Ment Market	2	Frederick Bailey	Lorraine		<b>y</b>		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel; or items 23a or 28e-f show entry or other treumetic event. If a Machical Examinet must be notified at once.		Mr. Robert Kane, Sr./ Husband 821	ailing Address (Street and Number or Rural R 6 Thorton Road Towso	Route Number, Ci n,Md。 2	ty or Town, State, 2 11204	Zip Code)	
ore	of He of He if item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition cemetery, (	sposition (Name of Date crematory or other place)	200	. Location - City or	Town, State	
Ē	Page tment o tent: If jury or			Valley Mem. 9-10-0		imonium,	Md.	
Bal	Depart Import eny in		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ruck Towson Funera 1050 York Rd. Tows	l Home,	Inc. 21204		
100	Physician /Medical Examiner	niner	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	enter the mode of dying, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death	
O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical Examiner	dical	In at initiated events resulting in death) Last  C. Due to (or as a consequence of):  d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliment	very Day Year
٥.	res that the de igned by the a be detached t		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?	
rds	w requires been sign should be	ed by	METASTATIC OVARIAN CANCER		1 ☐ Yes	2 <b>X</b> No 3 □ Pro	bably 4 Unknown	
Vital Records,		Completed			24a. Was an autopsy performed 1 Yes 2 X	prior to c death?	opsy findings available ompletion of cause of	
		o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2X No  Hospital: 1 X Inpatient 2 ☐ ER/Outpal	26. Place of Death C				
DIVISION OF	nding Phys th. :: After this s funeral di	h- 1	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation	e of 28c. Injury at 28d	Describe how in		ity)	
DIVIS	ef or Attendi s after death. I Director: A id in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f.	Location (Street City or Town, St	and Number or Rui ate)	ral Route Number,	
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edicai (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, and investigation, in my opinion, death occurred a	due to the cause at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)	
	To the within to the comp	ž	29b. Signature and title of certifler	29c. License number	29d. [	Date signed (Month,	Day, Year)	
			1 Com	> D 37254		9/6/0	4	
	6		30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)		1		
			31. Date filed (Month Gry per) 9 2004 32. Red strar's Signature	DRIVE, TOWSON, MA	RYLAND	21204		
	Sta Registra		31. Date filed (Month, Str. ped) 9 2004 32. Repstrar's Signature	Sporter				

				artment of Health and Mental H rtificate of Death	ygiene Reg. No. 0 0 4 28569
ľ	Physici	an	1. Decedent's Name (First, Middle, Last) William John Long, Sr.	2. Date of D Month	Day Year
	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	mber 6, 2004 4:00 A M
	E Admin	: :	4912 Tartan Hill Road	Perry Hall	Baltimore
\$	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  2.1.7 – 5.0 – 5.0.6.0 1 ☑ M 2 □ F 5.5 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of B Months Days Hours Min. (Month, D.	9. Birthplace (State or Foreign Country) Maryland
	Director		217-50-5960	Vec.	10,1948 Maryland
	yland how		10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
	Ba-fa	Director		erry Hall	1 ☐ Yes 2 ☑ No
	with the a or 2	Dire	10e. Street and Number 4912 Tartan Hill Road	10f. Zip Code	10g. Citizen of What Country?
	ns 23	Funeral		Was Decedent of Hispanic Origin? (Specify Yes or N	U.S.A.
9	or Itel	Fur	1 Never Married 2 Married 1 Never Married 2 No	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:	
9	72 hours after death with the Maryland natural', or Items 23s or 28s-1 show Iteal Examinet must be malified at	d by	3 Wildowed 4 Divorced Year or Dates:		Specify: White
15	n "nat	plete	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry  Motor Vehicle
21215-0036	d within ? giene. er than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4 Chief	Dept. Administrator	Administration
gud	be filed stal Hygi od other avent, II	Be	17. Father's Name (First, Middle, Last)  William R. Long	18. Mother's Name (First, Middl	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 Is marked other than "natural", or Items 23s or 28a-1 ahow other traumatic avent, the Medical Examinationals beautified at	2		Miriam Local and Number or Rural Route Num.	hman
	1 and 2 s Health ar em 27 ls	1	I	Stratman Road, Dundalk,	
Baltimore,	iges 1 a at of Hear Iffitem or othe		20a. Method of Disposition 1    20b. Place of Disposition 20b. Place of Disposition commeterly, creation 3 □ Removal from State	osition (Name of Date matery or other place)	20c. Location - City or Town, State
ij	tment of tant: If it itury or o		4 □Donation 5 □Other (Specify) Oak Lawn		Baltimore, Maryland
Bal	permit. Pages Department of Important: If i any injury or o	1 12		2. Name and Address of Facility Schimunek 9705 Belair Rd., Baltimo	
	Physician /Medical Examiner	ıer	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	nocarcing a the esopha	Interval Between Onset and Death
	ecutec and -transi	Examine	tratimitated sweets		
8760,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):		
687	ifficate g phys	edlc	d		
P.O. Box	that the death certificate be executed ted by the attending physician and detached for use as the burial-transit	Physician/Medical		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
	The law requires that the tee by the bas been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the un		tobacco use contribute to the cause of death?  Yes 2 ☑ 100 3 ☐ Probably 4 ☐ Unknown
of Vital Records,		Completed		24a. Wa auto perf 1 □ Yes	opsy prior to completion of cause of death?
Z <u>it</u>	Phyaician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death (Check only	
٥	g Phy ter this seral d	н.,	27. Manner of Death 28a. Date of Injury 28b. Time of	4 I Nursing Home 5 M Res	how injury occurred
sior	Attending or death. ector: After by the fune	catlo	2 Accident investigation	M 1 Yes 2 No	
Division	tal or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specity)	eet, factory, office 28f. Location City or To	(Street and Number or Rural Route Number, wn, State)
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one)  Cartifying Physician: To the best of my knowledge, death one)  Cartifying Physician: To the best of my knowledge, death one)  Cartifying Physician: To the best of my knowledge, death one)  Cartifying Physician: To the best of my knowledge, death one)  Cartifying Physician: To the best of my knowledge, death one)	n occurred at the time, date and place, and due to the vestigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier  Jamene J Love of	29c. License number  \$\mathbb{P} \ 301 \rightarrow \rightarrow \limits_{}	29d. Date signed (Month, Day, Year)
	141		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	7 0 0 7
	KI		Laurence J. Snyder ND 7505	Osler Dr. 502 Towson	n md 21204
	Sta Registr	4	31. Date filed (Month, Day, Year)  SEP 0 9 2004	Osler Dr. 502 Towson	

			1 - For State Registrar	State of	Maryland /		artmeni rtificate					giene	00%	20570			
	i i	) F' .	1. Decedent's Name (First, Middle, Last)  2. Date of De						ath 3 Time of Death			_					
	Physic /Medi		Joseph A. Lopez, Jr.				SEP 5			D		М					
	Examir	ner	4a. Facility Name (If not institution, give street and number) 303 Maiden Choice Lane Apt. 225			4b. City, Town, or Location of Death Catonsville				4c. County of Death Baltimore							
Ŀ	. Funeral Director		218-09-5660	6. Sex 7 1 M 2 □ F	7. Age (In yrs. last b 84	oirthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day JAN 7,	1920	Cou	place (State or Fore ntry) Land	ign		
	land land		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation							Od. Inside City Limi	ts		
	Mary a-1 sh	tor	Maryland Balt:	imore		С	atons	vill	Le					1 □ Yes 2 📉 N			
	th the	Director	10e. Street and Number				10f. Zip					10g. Citize	en of What Cou	ntry?			
	ath w 8 236	ral	303 Maiden Cho	oice Lane	Apt. 225				21228				USA				
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23s or 28a-1 show other traumatic event, the Madical Examinar in ust be invilited at	by Funeral	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	Armod Core	<sup>2□No</sup> WWII	- 1	Was Decedon f Yes, spec I ☐ Yes 2		spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	ľ	4. Race - Americ Black, White, Specify:				
9	2 hou	ted	15. Decedent's	Education		a. Deced	lent's Usua	I Occupa	ation			16b. Kind	d of Business/In	dustry			
21215-0036	thin 7: e. an "n	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of word		luring mos )	t of worki	ng			,			
121	led w tygien her th		8			D	rafts	man					Marine I	ndustry			
Maryland	12 should be filed within n and Mental Hygiene. 'is marked other than' raumatic event, the Me	Be c	17. Father's Name (First, Middle, L.	ŕ							(First, Middle, i		,				
Ž	shoulk nd Me mark imatic	스	Joseph A. Lo		19	b. Mailin	a Address	(Street a	Mar and Numbe	gare	et Agnes	McG	uiness Town, State, Zip	Cadal			
	Health ar	1	Margy Zuwallack								ethorpe			Code)			
J.e.	of He		20a. Method of Disposition		20b. Place	of Dispo	sition (Nam	e of		9/9/	ate		ation - City or To	wn, State			
Ē	Pages ment of h ant: If ite ury or of		1 ☐ Burial 2 ☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Specific Control of Cont		Baltin	-		•	·			Ba	ltimore	, MD			
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature o Funeral Service Li Dawii F . Mc	Donald	ald	22	MacNai	Addres DD F	s of Facilit unera	и но	me, P.A	. gwil	la MD '	21228			
	Physician /Medical Examiner		Dawn F. McDonald 301 Frederick Road Catonsville, MD 21228  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Interval Between														
			Immediate Cause (Final disease or condition resulting in death)	_a. M!	YOCARI	DIA	L	INF	ARC	TIO	N		9	Onset and Death			
			resulting in death)	Due to (o	r as a consequence	of):											
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.														
VA		Examiner															
oʻ	a exec an an irial-tr	Еха	resulting in death) Last	CDue to (or	r as a consequence	of):											
68760,	cate be executed physician and the burial-transit	dical		d													
.O. Box 68	ding Physician: The law requires that the death certi h. After this certificate has been signed by the attending tuneral director, page 2 should be detached for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birt	ome of pregnancy th 2  Fetal death nt at time of death vn		Ectopic pre Other (spe					230	d. Date of delive Month	ry Day Year			
Δ.				by Ph	Part II. Other significant condition					use give	n in Part I.		23e. Did tob	acco use	contribute to th	e cause of death?	
rds							1 ☐ Yes			s 2 🗆	2 No 3 Probably 4 Denknown		า				
		Completed									24a. Was ar autops perform	y	24b. Were autop prior to con death? 1 🔲 Yes	osy findings available pletion of cause of	Э		
Vital		Be	25. Was case referred to medical examiner?	Literaine							Check only one	9)					
of		. To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								)						
		1 Natural 5 Pending investigation investigation 3 Suicide 6 Could not be determined elegation at the suicide of							oa. Describe no	cribe how injury occurred							
Division									8f. Location (Str City or Town	ocation (Street and Number or Rural Route Number, City or Town, State)							
	Hospita 24 hours 7-uneral etely fille	edical C	29a. Certifier (Check only one) Certifying Medicel Ex	Physician: To the beaminer: On the bas and manne	est of my knowledg is of examination ar ir stated.	e, death	occurred at estigation, i	t the time	e, date and inion, deat	place, ar h occurre	nd due to the ca d at the time, da	use(s) an	nd manner as sta ace, and due to	ited. the cause(s)			
	To the within 2 To the complet	Me	29b. Signature and title of certifier		01	11	29c.	License	number		29	d. Date s	signed Month, D	Pay, Year)			
)			Xeslie	But	ceso	MI	7	000	060	57	6	9/8	3/04				
	6		30. Name and address of person who in the contract of the cont	no completed cause	of death (Item 23a)	(Type, F	Print)	ne	, N	ran	land	21	201				
	Sta Registr	2	31. Date filed (Month, Day, Year) SEP 0	9 2004 P	of death (Item 23a)	K,	food	V					- 1				

	15.3	State of Maryland Department of Health and Mental Hyging Amend Item 23a per Dr., G835, 09709/04dhb Registrar  1. Decedent's Name (First, Middle, Last)  State of Maryland Department of Health and Mental Hyging Certificate of Death  Re  2. Date of Death	- C C	28571					
Physic /Medi Examii	cal	Charlie Mae Lewis  Charlie Mae Lewis  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	03, 2004 4c. County of De	10:03 A h					
. Funeral Director		Cherrylane Nursing Center  5. Social Security Number 378-28-5232  Usual Residence of Decedent  Cherrylane Nursing Center  7. Age (In yrs. last birthday) 1	Prince G	eorges irthplace (State or Foreig Jountry) nknown					
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other then "neturel; or items 23s or 28e-f show other treumatic event, the Marical Examinations and item at	Funeral Director	10a. State 10b. County 10c. City, Town or Location	ig. Citizen of What C USA	10d. Inside City Limit 1 ☐ Yes 2 🟋N country?					
72 hours after de neturel', or items	by	3 ♥ Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 ▼ No Specify:	No-  14. Race - American Indian, Black, White, etc.  Specify: Black  16b. Kind of Business/Industry						
2 should be filed within and Mental Hygiene. Is marked other then "eumatic event, IIIs Market	Be Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Midd	Housekee	ping					
es 1 and 2 should be for Health and Mental I fitem 27 is marked of rother treumatic eve	To	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, Alice Ann Finnerty/Caregiver  20a. Method of Disposition  20b. Place of Disposition (Name of Date 20)		d 21218					
permit. Pages Department of I Importent: If its any injury or o	1   Burial 2   Cremation 3   Removal from State   Metro Crematory Inc.   9/4/04   Baltimore     21. Signature of Funeral Service Ligensee   22. Name and Address of Facility   Cremation Society Of Maryland, Inc.     29   Frederick Road Baltimore, Maryland   Maryl								
Fry Sician Medical Examiner  [Proposition and International Proposition of the Propositio	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Betwood Int							
law requires that the death certificate b as been signed by the attending physic 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   5   Other (specify)   1   1   1   1   1   1   1   1   1	23d. Date of de Month	livery Day Year					
w requires that s been signed b s should be deta	Completed by Pl	Part II. Differ significant conditions contributing to death but not resulting in the underlying cause given in Part I.	2× No 3 □ P	e contribute to the cause of death?  No 3 Probably 4 Unknow  24b. Were autopsy findings available					
Physician: The this certificate h ral director, page	To Be	25. Was case referred to medical examiner?  1	prior to death? No 1 Yes	completion of cause of					
spitel or Attending Isours after death. The Director: After filled in by the funer	Certification:	Natural 5 Pending investigation 3 Suicide 4 Homicide 4 Homicide 4 Homicide 5 Pending investigation 5 Pending investigation 6 Could not be determined 6 Place of Injury At home, farm, street, factory, office 286. Location (Stree City or Town, Street, factory)	28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)						
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier (Check only one)  29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, date occurred at the time, date o	se(s) and manner as a and place, and due Date signed (Mont	to the cause(s)					
Sta Registr	A 10	te 31. Date filed (Month, Day, Year) 32. Registrar's Signature	College P.	K MD 20					

			1- For State of Maryland / Dep	partment of Health and I ertificate of Death		000	20070					
	Physic	an an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Pay Ve									
1	/Medi	cal	Robert Marshall Leftwich, Sr.  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Septembe	r 4, 2004	9:20 A M					
	Examir	er	2527 Creighton Avenue	Baltimore	n	4c. County of Deat N/A	h					
	Funeral Director	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Jan. 2, 1	9. Birti	nplace (State or Foreign untry)					
	D	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or 1	ocation	Juli. 2, 1	732 00	rginia					
Maryland 21215-0036	n 72 hours after death with the Maryland "natural", or Itams 23s or 28s-1 show wined Examiner must be natified at		Maryland N/A	Baltimore			10d. Inside City Limits 1   Yes 2   No					
		Director	10e. Street and Number 2527 Creighton Avenue	10f. Zip Code 21234	10g.	Citizen of What Co	.,					
		Funerai		. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Amer	ncan Indian,					
		To Be Completed by Fu	1 Never Married 2 Married 1 X es 2 No 3 Widowed 4 Divorced 1 Yes, Give Korean Year or Dates Conflict	if Yes, specify Cuban, Mexican, Puerti 1 ☐ Yes 2 ☑ No Specify:	o Rican, etc.)	Black, White	o, etc. White					
	d within 72 ho piene. r than "natur The Medical I		15. Decedent's Education 16a, Dec	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	kina	. Kind of Business/I	,					
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, ITE Mas and DOCE.		Liementary/Secondary (U-12)   College (1-40f 5+)	ce Sergeant		altimore lice Depa						
			17. Father's Name (First, Middle, Last)  Marshall Chesterfield Leftwich		ne (First, Middle, Maid 2. Virginio							
			19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ling Address (Street and Number or Ru	ral Route Number, Cit	ty or Town, State, Z	ip Code)					
	1 and Health am 27 thar tr		Mrs. Joann G. Leftwich (wife) 252  20a. Method of Disposition 20b. Place of Disp			MD 212.						
MOL	Pages nent of I ant: If its ury or o		Tabolita E Coldination o Citionoval nom otate	ematory or other place)	/2004 Ba							
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar once.			22. Name and Address of Facility Sc	chimunek Fu	ineral Hoi	nes					
		1	9705 Belair Rd., Baltimore, MD 21236  23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate Interval Between									
	Physician /Medical	8	Immediate Cause (Final disease or condition as Judden Caresulting in death)	RDIA ARRYTU			Onset and Death					
0,	Examiner  bhysician and ithe burial-transit		Due to (or as a consequence of):									
		Examiner	Tally, leading to immediate cause. Enter Underlying Cause (Disease or injury									
		Exar	resulting in death) Last Due to (or as a consequence of):									
38760,	icate be physici s the bu	dicai	d									
.O. Box 6	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death, the standard shared between Director After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	o Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the cast 13 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	Dectopic pregnancy		23d. Date of deliv	. Date of delivery					
				Other (specify)		Month	Day Year					
S, D			by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?				
Record			Mayers davis									
			- Hyper I, pidemia		24a. Was an autopsy performed 1 Yes 2 X 1	prior to co	opsy findings available impletion of cause of					
Vital			25. Was case referred to medical examiner?  1 \sum Yes 2 \sum No Hospital: 1 \sum Inpatient 2 \sum ER/Outpatie	Other	th (Check only one)							
Division of		-	1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death 1 ☐ Inpatient 2 ☐ ER/Outpatie  28a. Date of Injury (Month, Day Year) Injury	THE SELECT THE RUISING HE	Home 5 √ Residence 6 □Other (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number,							
/isio		ertification;	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home farm st	M 1 Yes 2 No								
2		Certif	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ru City or Town, State)									
	e Hosp 24 hou a Fune letely fil	edicai	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal (2 ☐ Medicel Exeminer: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as s nd place, and due to	tated. o the cause(s)					
	To th within To th comp	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, I									
	. 1-1		30. Name and address of person who completed cause of death (Item 23a) (Type,	D 4460	7	9/7/	04					
	171		MICHAEL SUTTER MD 9512 HARROOD		AUTIMORE	MD	21234					
	Sta Registr	_	31. Date filed (Month, Day, Year)  SFP 0 9 2004  32. Registrar's Signature	South 1								

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 170(X INSK 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5807 KINS BUYRIE Street 9 If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** <sup>Year)</sup> 1948 Days Months 1 M 2 □ F Hours 217-52-1803 56 Director Marvland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 No Glen Burnie Maryland Anne Arundel Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 5807 Elkins Street 21061 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Specify: 3 ☐ Widowed 4 M Divorced "neturel', White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Correctional Officer Baltimore County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of ပ Joseph Lonczynski Charlotte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 5807 Elkins Street Glen Burnie, Maryland 21061 <u>Charlotte M. Lonczynski (Mother)</u> 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
any injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Pk. 9/7/04 Glen Haven Mem. Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. line 237 East Patapsco Ave. Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** triterioscleratio /Medical Due to (or as a consequence of) Examiner 4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and is the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ◯ No 24a Was an page 2 s certificate 1 ☐ Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death Check onl. one) 1 Yes 2 No Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Seidence} \) 6 \( \text{Other} \) (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Janner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No filled in by the fu 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerel Direct completely filled in by 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Deputy person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State Registrar

			1 - For State Registrar	State of M	arylan		artmen rtificat				1ental Hy	giene	1000	20575
	Dhysia		1. Decedent's Name (First, Middle, Last,	)							2. Date of De	eath		3. Time of Death
1	Physic /Medi		Raymond A. Le	ewandowsk	i						Sept 5	5, 20°	04 Year	21:06 P M
1	Examir	ner	4a. Facility Name (If not institution, give s Southern Maryland				-	Town, or Linto	Location of	of Death			County of Dea	
	Funeral		5. Social Security Number 6. Sec			ast birthday)	If Under		If Under	24 Hrs.	8. Date of Bi	rth	0.8:	George's
	Director			M 2□F	82	Yrs.	Months	Days	Hours	Min.	Dec 12	ay, Year)	21 Wis	thplace (State or Foreign ountry) SCONSIN
	and *		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	anting							
	Maryli f sho fed a	Ď	Maryland Prince (	George's	Too. Oity	, rown or Lo		oer M	lar1b	oro				10d. Inside City Limits 1 ☐ Yes 2 🗓 No
	r 28a	Director										10g. Citiz	zen of What Co	****
	23a c	a D	12203 Westview Drive 20772									Uni	ted Sta	tes
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23a or 28a-f show entry injury or other treumetic event, the Midical Examiliar must be notified at ance.	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☑ Married  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								p- 1	14. Race - Ame Black, Whit		
936	urs aft	þ	3 ☐ Widowed 4 ☐ Divorced	1 <b>∑ Y</b> es 2 ☐ f If <del>Yes</del> , Give Year or Dates:	No WWI	I .	I□Yes 2	XX	Specify:				Specify: W	hite
21215-0036	72 ho	Completed	15. Decedent's Educ (Specify only highest grade			16a. Deced	lent's Usua	Occupa	tion			16b. Kin	nd of Business	
121	han han	mple	Elementary/Secondary (0-12)	College (1-4or 5	5+)		kind of wor OO NOT us	e retired)	uning most	or work!	ng			
Q 25	filed v Hygie other t		17. Father's Name (First, Middle, Last)			Geogo	list		18 Mothe	r's Namo	(First, Middle		ept of	Engery
an	lid be lental rked c	To Be	Jozef Lewandows	ski					TO. INICITIE		onela		,	
Maryland	2 shou and N Is ma eumai		19a. Informant's Name/Relationship (Ty)							r or Rura	l Route Numb	er, City or	Town, State, 2	
e)	l and lealth im 27 her tr		Angela Lewandowsk	(MTLF)	OOL DI	1220	3 Wes	tvie	w Dri					D 20772
Baltimore,	ages nt of h h: If ite		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ R	emoval from State		ace of Dispos metery, crem				ot 10	), 2004		ation - City or	
Ħ	artme orteni injury		*4 ☐Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	6 /	Re	esurre					Funer	Clir	nton, M	aryland 6633 Old
ä	Depa Impo eny ir		VIII DOL	A poo	153	3 A1	exand	ria	Ferry	Rd,	Clint	on, M	me, inc	d 20735
	Dh. sisiss		23a. Part 1. Enter the disease, or complications, or heart failure. List only on immediate Cause (Final	e cause on each in	10.							rrest,		Approximate Interval Between Onset and Death
1	Ph, sician /Medical		disease or condition resulting in death)	Due to (or as:	a cons que	cavolia	1-10	rvot	וכטו					
	Examiner		Securificity list conditions b	Ische	nic C	ardio	rasul	dr"	Dise	sse				
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):			23111					
	execut n and al-trar	Exan	that initiated events c. resulting in death) Last	Due to (or as a	a conseque	ence of):								
8760,	ficate be executed physician and is the burial-transit	dical	d											
9	entifica ing ph e as th	Med	IF FEMALE:									100		
P.O. Box	that the death certificated by the attending produced for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1□Live birth	2 🗌 Fetal c	death 3 🔲	Ectopic pre					23	d. Date of deli-	very Day Year
o.	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	ath 5∐	Other (spe	cify)					World	Day
	The law requires that the ite has been signed by thoage 2 should be detache	y P	Part II. Other significant conditions conf	tributing to death bu	ıt not result	ting in the un	derlying ca	use giver	in Part I.		23e. Did to	bacco use	e contribute to	the cause of death?
ğ	w require been sig should b		Hypertension	И							1 🗆 Y	'es 2□	No 3 ☐ Pro	bably 4 Unknown
Ö	a law r nas be e 2 sh	Completed									24a. Wasa autop	an sv	24b. Were aut	opsy findings available ompletion of cause of
al H	sicien: The law certificate has t rector, page 2 s										perfor	med? 2. No	death? 1 ☐ Yes	
<u> </u>	sicien: Th certificate rector, pag	Be c	25. Was case referred to medical examiner?	ospital:		1		Other			(Check only or			
ō	g Phys er this eral dir	n: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 ☐ Inpatier 28a. Date of Injury	y 2	R/Outpatient 28b. Time of	3□ DOA	c. Injury a	ut Nurs		e 5 🗆 Resid 8d. Describe h		Other (Speci	fy)
loi	anding F sath. or: After ne funer	atio	1 ☑ Accident 5 ☐ Pending investigation	(Month, Day	Year)	Injury	м	Work?	s 2 N					
Division of Vital Records,	el or Attendir s after death. I Director; Al d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc.	ry - At hom . (Specify)	e, farm, stre	et, factory,	office		21	3f. Location (S City or Tow	treet and I	Number or Rur	al Route Number,
	e Hospitel ( 24 hours al e Funerel D letely filled i		29a. Certifier 1 Certifying Physi	cies: To the best o	f many ten monet									
	To the Hospitel or Attending Physicien: within 24 hours after death To the Funerel Director: After this certifica completely filled in by the funeral director, to	Medical	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examine	er: On the basis of and manner stat	examinatio	on and/or inve	estigation, i	n my opir	ion, death	occurred	at the time, d	ause(s) ar late and pl	nd manner as s lace, and due t	stated. o the cause(s)
	To the vithin To the comple	ž	29b. Signatule and title of certifier	-				License r		í			signed (Month,	
	11/1		JOOQUE					40	324			SEPTE	MBER	5,2004
	1811		30. Name and address of person who con TERRY A. JODRIE, MD	7035				C	181/77 n 2	MA	RYIA	\ _>	0735	
	Sta	e_	31. Date filed (Month, Day, Year) SEP 0 9 2004	3 Registral			Les .		1010	3 1 4 (7)	,- [ LiTIU		- / 35	
	Registra	ar I	SFP 0 9 2004	Colore Mar	1 10	1								

			1 - For State Registrar			Marylan		artmen rtificate			and M	ental Hy	giene	2001	28576
H	Physici	an	Decedent's Name (First	st, Middle, Last)							C	2. Date of De	aath DE Da	y <sub>6,2</sub> %	3. Time of Death
	/Medic Examir	cal	John Ma 4a. Facility Name (If not in Saint Jo	<u>rtin</u> institution, give s seph ly	Lantz street and num ledica	ber)	er.	4b. City,	Town, or	Location o	of Death			. County of I	
	Funeral Director		5. Social Security Number 214-30-4410	1 <b>X</b>	M 2□F	. Age (In yrs. I	last birthday) Yrs.	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da 6/3/19	th ay, Year)		Birthplace (State or Foreign Country) ennsylvania
	Maryland f show	lor		. County arford			/, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 💆 No
	th the or 28a.	Director	Maryland H 10e. Street and Number	arroru		вет	Air	10f. Zip	Code				10g. Ci	tizen of Wha	t Country?
	s 23e		1306 "F" Sc					210						S. A.	
980	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28a-1 show ta Madical Examiriast be notified at	by Funeral	11. Marital Status  1 □ Never Married 2  3 ☑ Widowed 4 □ □	2 Married	12. Was Deced Armed Ford 1 □¥es 2 If Yes, Give Year or Dat	es? □ No 195	4	Vas Deced f Yes, spec I □ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)	>-		American Indian, Vhite, etc. White
Maryland 21215-0036	d within 72 ho piene. r than "natur r e Medical	Completed	(Specify on Elementary/Secondary	Decedent's Educity highest grade	cation completed) College (1-4		16a. Deced (Give life. L	kind of wor DO NOT us	k done di e retired)	urina most	of workin	g		and of Busine	ess/Industry
d 2	77 75 5 5		12 17. Father's Name (First,	Middle, Last)			Drai	tsman		18. Mother	r's Name	(First, Middle,		Steel I	Mill
/lan	2 should be and Mental is marked c	To Be	Paul Ma	rtin	Lantz					Alic		Layt		,	
Man	ges 1 and 2 should be filed t of Health and Mental Hyg If item 27 is marked othe or other traumatic event,		19a. Informant's Name/R		•							Route Number			
	of Health item 27 other tra		Michael Ian 20a. Method of Dispositio	on			ace of Dispo	1 Lee	e of			njsvil			087 or Town, State
Baltimore,	Page ment o ant: If ury or		1 ØBurial 2 ☐ Cre `4 ☐ Donation 5 ☐		emoval from St	ate	emetery, ciren dens o			´ I	ery	9/11 2004	Bal	timore	e, Maryland
Balt	permit. Pages 1 Department of H Important: If ite any injury or otl once.		21. Signature of Europeal		The	4	- B	407 o	insk ld E	i Fur aster	neral n Av	Home :	PA Esse		cyland 21221
	Pnysician		234. Part 1. Enter the dis- shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	ease, or compli ure. List only on	e cause on eac	ised the death th line.	. Do not ente	or the mode	of dying	, such as o	ardiac or	respiratory ar	rrest,	•	Approximate Interval Between Onset and Death HOURS
	/Medical Examiner			ns. b	CARD	as a consequ [OMYOF	ATHY								YEARS
8760,	icate be executed physicien and s the burial-transit	dical Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.		as a consequ									
9	eath certificat attending phy for use as the		IF FEMALE:	23	Bc. If yes, outco	me of pregnar	ncv								
.O. Box	that the death led by the atter detached for u	by Physician/Me	23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	i i di i i	1 Live birt	n 2∏Fetal It at time of de	death 3 🗌	Ectopic pre Other (spe						23d. Date of Month	delivery Day Year
rds, P	og De	ed by P	Part II. Other significant of	conditions con	tributing to dea	th but not resul	Iting in the un	derlying ca	use giver	in Part I.		23e. Did to	,		s to the cause of death?  Probably 4 □Unknown
al Records,	: The law re cate has be , page 2 sh	Completed				· · · · · · · · · · · · · · · · · · ·			<del>-</del>		<del></del>	24a. Was autop perfor 1 Yes	sy	24b. Were prior to death	
Vital	sician certifi rector	o Be	25. Was case referred to examiner?		ospital:				Other			Check only of		200 - E.	
Division of	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funeral Diractor: After this certificate he completely filled in by the funeral director, page	$\vdash_{\square}$	2 Accident	Pending investigation	28a. Date of		R/Outpatient 28b. Time of Injury		c. Injury a Work?	at □ Nur:	28	e 5 ☐ Resid d. Describe h			oecify)
Divis	tel or Atters as after de al Diracto	Certification:	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of building	Injury - At hon , etc. <i>(Specify)</i>	ne, farm, stre	et, factory,	office		28	f. Location (S City or Tow	itreet and n, State)	d Number or	Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	one)		cian: To the beer: On the basi and manner	s of examination	rledge, death on and/or inve	estigation, i	n my opir	nion, death	place, an occurred	at the time, o	date and	place, and d	ue to the cause(s)
1	To Con	2	29b. Signature and title of	T (L	elou,	M.	<b>D</b> .		License r						onth, Day, Year) 6, 2004
j	241		30. Name and address of	person who con	npleted cause of	of death (Item :	23а) (Туре, Р						/		
_	Sta	e	ABDALLAH 31. Date filed (Month, Day	J. HEL	32. Reg	760 istrar's Signa	40		RIV	E TO	WSON	i, MAR	LAN	D 218	2714
	Registra		SEP 0 9		Sere	2	Sp	als							

29a. Certifier

3 ☐ Suicide

4 - Homicide

**Physician** 

/Medical

Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example continued as once.

**Physician** /Medical

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

Plea	ase Type or Pri	int in Blac	ck Ind	elible Ink	Ensur	re All	l Copies	Are I	eaible	<b>.</b>	
		Maryland / [							.09	•	
1 - For State Registrar				ificate of		,		Reg. No.	001.	0	0077
Decedent's Name (First, Middle	le, Last)						2. Date of Dea	ath	<del>UU4</del>		Time of Death
WINIFRED	LONES	OMÉ_					Month 09	Day Day	Year DY	1 1	1 : SI AM
4a. Facility Name (If not institution			4	4b. City, Town, o	or Location of	Death			County of De		
	HOSPITAL			BALT							
5. Social Security Number 216–12–9688		Age (In yrs. last bir	birthday)	If Under 1 Year Months Days	If Under 24	Min,	8. Date of Birtl (Month, Day 10 20		-	Birthplace Cou <i>ntry)</i>	(State or Foreign
Usual Residence of Decedent			- or Loca	41.						104	Charles India
		10c. City, Tow									Inside City Limits  XXYes 2 □ No
MD NA	<u> </u>	Balti		1				Chie	******		
10e. Street and Number				10f. Zip Code				•	en of What C	•	
4305 Miami P		7 - 1-110	12.14		207	2 (220			U.S.A		
11. Marital Status	12. Was Deceden Armed Forces	s?	13. wa	as Decedent of H Yes, specify Cuba	ilspanic Origin an, Mexican, f	1? (Spec Puerto P	cify Yes or No- Rican, etc.)	. 14	4. Race - An Black, Wh		idian,
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d If Yes, Give Year or Dates	s:		□Yes 21XNo						Blac	
15. Deceden (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or		. Deceden (Give kir life. D(	ent's Usual Occup ind of work done O NOT use retired	ation during most o	of workin			d of Busines	,	•
12th grade	na na	5+)	A	nalyst				Fede	eral	Gove	ernment
17. Father's Name (First, Middle,	Last)			1	18. Mother's	s Name	e (First, Middle,	, Maiden S	Sumame)		
William Montg	omery				Li11'	ie 1	Morgan	a.			
19a. Informant's Name/Relations		191	b. Mailing	Address (Street	-				Town, State	a, Zip Cod	(e)
Leroy Albert  20a. Method of Disposition  Communication  4 Donation 5 Other (S		20b. Place of cemeter	of Dispositi tery, cremat	Scher: atory or other place Memoria	ice)	Da	Date	20c. Loca	cation - City o	or Town, S	
21. Signatur A Funeral Service	Licensee Shu	ignet	22. N Mai 430	Name and Addre	ess of Facility H West ash Av	t ve,	Balti	imore		3 2]	1215
23a. Part1. Enter the disease, or strock, or heart failure. List Inimediate Cause (Final disease or condition resulting in death)	a. Myo	sed the death. Do not line.  CARDIA as a consequence	o not enter t		ing, such as car	ardiac or				Appr	proximate erval Between set and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b		2EE e of):	HEAR			K				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 ☐ Fetal death t at time of death		Ectopic pregnancy Other <i>(specify)</i>	/			23	3d. Date of de Month	delivery Day	Year
Part II. Other significant condition  SIP Explor				arlying cause giv	en in Part I.			obacco use Yes 2 121			use of death?
						-		psy prmed?	prior to death?	o completion	indings available tion of cause of
25. Was case referred to medical examiner?						of Death	(Check only on				
examiner? 1 Ves 2 No	Hospital: 1 Inpat	atient 2 ER/Ou	Jutpatient	3LI DOA		ing Hom	me 5□Reside	Jence 6	□Other (Sp	secify)	
27. Manns of Death  1 P Natural 5 Pendin 2 Accident investig	ing (Month, D	njury 28b. Day Year)	. Time of Injury	28c. Injun Work	ry at irk? ]Yes 2 □ No		28d. Describe h	ow injury o	occurred		

Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

anding physician and use as the burial-transit ed by the attending physician detached for use as the burial To the Hospitel or Attending Physiclen: The law requires that th within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detact

Certification: To Be Completed by Physician/Medical

Medical

State

Registrar

29b. Signature and title of certifier

BANTAYEHU

SILESHI RESIDENT-000

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

09/01/04

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BANTAYEHU SILESHI MD

22. Registrar's Signature 31. Date filed (Month, Day, Year)

SEP 0 9 2004

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

SINAI HOSPITAL

56	95		State of Maryland / De	epartment of Health and Menta	I Hygiene			
			1 - State Registrer  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. 2005	70		
ı	Physici		Korey Morris	Mor				
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
			Sinai Hospital	Baltimore  ay) If Under 1 Year   If Under 24 Hrs.   8. Date	N/A			
ľ	Funeral Director		5. Social Security Number 216-06-8211 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min. (Mor	e of Birth Place (State or Country)  9. Birthplace (State or Country)  y 21,1984Maryland	<sup>*</sup> Foreign		
	land bw		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town o	r Location	10d. Inside City	v I imits		
	Mary 9-f sh	tor	Maryland N/A Bal	timore		1 🙀 Yes 2 🗌 No		
	h with the 23e or 28	al Direc	10e. Street and Number 4025 Hilton Road	10f. Zip Code 21 21 6	10g, Citizen of What Country?			
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, Ite Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 ★Never Married 2 ★Married  3 ★Widowed 4 ★Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 ★Yes ★ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e     □ Yes 2 No Specify:	s or No- ltc.)  14. Race - American Indian, Black, White, etc.  Specify: Black			
20	72 hou	eted	15. Decedent's Education 16a De	cedent's Usual Occupation live kind of work done during most of working	16b. Kind of Business/Industry			
21215-0036	within ane. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retirea)	Private Industr	V		
g 5	Hygie other ant,	Be Co	12th grade   Labo	18. Mother's Name (First, )	Middle, Maiden Surname)			
Maryland	ould be Menta arkad atic ev	To B	Nathaniel Morris, Sr.	Franchester				
	and 2 shealth and 2.27 is m		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Franchester Dorsey/ Mother 174	ailing Address (Street and Number or Rural Route 13 N. Bond Street Ba	Number, City or Town, State Zip Code 213			
Baltimore,	Pages 1 ament of He ent: If itan ury or oth		Cemetery (	sposition (Name of Date crematory or other place) emorial Park 9/10/04	20c. Location - City or Town, State Woodlawn, Maryl	and		
Balt	permit. Departr Importa		21. Signature of Juneral Service License	22. Name and Address of Facility Chatma 5240 Reisterstown Ro	n-Harris Funeral Baltimore, Md 21	Home 215		
	Ser.		23a. Part1. Inter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respira	Interval Between	/een		
	Physician /Medical			with Words	Onset and De	əath		
	Examiner		Due to (or as a consequenc of):					
	p #	iner	Sequentially list conditions, if any, leading to immediate cause Finter Industrying					
9	ficate be executed physician and is the burial-transit	Examiner	Cause (Disease or injury that initiated events c. subject that initiated events resulting in death) Last c. Due to (or as a consequence of):					
8760,	ysician e buris	dical E	d					
9	artifical ing phy e as th	Medi	IF FEMALE:					
.O. Box	at the death certifi by the attending rtached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery  Month Day Ye	∍ar		
0	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	a underlying cause given in Part I. 23e	. Did tobacco use contribute to the cause of dea	ath?		
ords	w require: been sig should be				1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 IXOn	ıknown		
Records,	The law ri	ompleted		24a.	. Was an autopsy findings av prior to completion of cau death?	/ailable use of		
Vital		O	25. Was case referred to medical	1 1 26. Place of Death (Check	Yes 2 No 112 Yes 2 No			
	Physician: this certific ral director,	ToB	examiner? 1 [XYes 2 □ No Hospital: 1 □ Inpatient 2X ER/Outpat	Other	Residence 6 □Other (Specify)			
בס	ding P h. After t funera	:lon:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28b. Time (Month, Day Year)	Work?	cribe how injury occurred			
Division of	el or Attandi safter death. I Diractor: A d in by the fu	ifical	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		tion (Street and Number or Rural Route Numbe	er.		
ā	tel or rs afte el Dira	Certification:	building, etc. (Specify)	strut the	tion (Street and Number or Rural Route umber or Town, State)	oyay		
	To the Hospitel or Attanding within 24 hours after death. To tha Funerel Diractor: After completely filled in by the fune	edical	29a. Certifier  (Check only one)  One)  Chack only one)  One)  Chack only one)  Addical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due t investigation, in my opinion, death occurred at the	o the cause(s) and manner as stated. time, date and place, and due to the cause(s)			
	To the Hos within 24 h To tha Fur completely	Med	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)			
	1		Theoder U. 16:01	O.C.M.E.	September 3, 2004			
	5		30. Name and address of person who completed cause of death (Item 23a) (Typ					
	Sta		31. Date filed (Month, Dav. Year) 32. Registrar's Signature	111 Penn Street, Baltim	ore, maryland 21201			
	Registr		SEP 0 9 2004 Kerse K. An	10				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year Thomas Francis Malooly 5:50P M Sept. 5 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3 Lord Guy Terrace Ocean Pines Worcester If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 □ F Director 218-01-0119 82 3/24/1922 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28e-f show the Medical Example of restrict by notified at MD WORCESTER 1 ☐ Yes 2 No Funeral Director OCEAN PINES 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "--- any injury or other traument." 3 LORD GUY TERRACE 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☐xNo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COMPTROLLER SCIENTIFIC RESEARCH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THOMAS FRANCIS MALOOLY MARY KINLEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNN MALOOLY 3 LORD GUY TERRACE WIFE OCEAN PINES. MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY 9/9/2004 BALTIMORE, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. 23a Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. TOWSON. MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MULTIPLE MYELUMA GEARS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) o the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OBSTRUCTURE PURMOMPHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Unknown DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 **Z**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 🔀 No this ierel Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 EASTERN SHONEDR. SALISBURY MD RENE DESMARAIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar SEP 0 9 2004

**ORIGINAL** 

		1	_ For	partment of Health and Mer Pertificate of Death	ntal Hygier	0001 00000
	Physicia	_	1. Decedent's Name (First, Middle, Last)  Jane Claire MacPhail		Date of Death Month  eptember	3. Time of Death 7 2004: 1847
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
1			Carroll Hospital Center	Westminster		Carroll
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) $064-22-3459$ $1 \square M 2 \square F$ 78 Yrs.	/) If Under 1 Year If Under 24 Hrs. 8.  Months Days Hours Min.  Ma	Date of Birth (Month, Day, Yea arch 13 1	9. Birthplace (State or Foreign Country) NY
	D		Usual Residence of Decedent			10d, Inside City Limits
	after death with the Maryland or Items 23a or 28a-f show in their must be notified at	ō	10a. State 10b. County 10c. City, Town or 1 Sykes	ville		1 X Yes 2 □ No
	28a-	Funeral Director	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?
	th with	ai D	7426 Village House Apt 310	21784	US	SA
		ner	Armed Forces?	. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.
36		by Fu	1  Never Married 2  Married 1  Yes 2  No If Yes, Give X 3  Widowed 4  Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: White
2-0	n 72 hours "naturel", edicel Exe	eted	(Specify only highest grade completed) (Given	edent's Usual Occupation re kind of work done during most of working	16b.	Kind of Business/Industry
21215-0036		Completed	College (1 der 5)	k of the court	jι	ıdicial
d 2	fygi her nt, I	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (F		
Maryland	es 1 and 2 should be fi of Health and Mental F I item 27 is marked of r other treumatic ever	ToB	Harry Dare Reynolds	Marion Eli		
Mar	12 sho h and 7 Is m			Hing Address (Street and Number or Rural R Cindy Ln, Westminst		
	Healt tem 2		20a. Method of Disposition 20b. Place of Dis	position (Name of Date ematory or other place)		Location - City or Town, State
BO	Pages sent of int: If i		1 □ NBurial 2 □ Cremation 3 □ Hemoval from State  4 □ Donation 5 □ Other (Specify)  Lake Vie	w Memorial 9-10-04		esville, Md
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 2002.		21. Signature of Funeral Service Licensee  Page Haight Herbert	<sup>22. Name and Address of Facility</sup> Haigh P.O. Box 195 Sykesvi	nt Funera	1 Home & Chapel 21784
8760,	Physician /Medical Examiner  this privativansit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not eashook, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C	ed Abdomina	_	Approximate Interval Between Onset and Death Lours Lours Lours
P.O. Box 6	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/Med		B □Ectopic pregnancy S □ Other (specify)		23d. Date of delivery Month Day Year
	res that igned b	by P	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?  2 ☑ No 3 ☐ Probably 4 ☐ Unknown
ord	w require been sig	eted	A Johnson Coagui	o party	-	
Rec	The law te has bage 2 s	ompi	Vae pair Kuptured	- /Thedominal	24a. Was an autopsy performed:	
ita	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (C		
of V	Physic this ce al dire	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpat		5 Residence	6 ☐Other (Specify)
on	ding F th. : After s funera	tion	27. Manner of Death  1 12 Natural 5 Pending (Month, Day Year)  2 Accident investigation		a. 50001150 11011 II	, a.y 55561152
Division of Vital Records,	l or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f	f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, de a company one)  12 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and investigation, in my opinion, death occurred	d due to the cause at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To thin Within To thi compl	Me	29b. Signature and title of certifier	29c. License number	29d. l	Date signed (Month, Day, Year)
•	()		Vyhent Lordon Ma	D0020554		7/8/04
	Λ			HINGTON HEIGHT	TS W	estminster 2115°
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	de		

			State of Maryland / Department of Health and M 23c,,PtII,25,27,28a-fr per MF 835,09/	ental Hy <b>03/04d</b>	giene	4 2858	the enables
	Physici /Medic		1. Dacedent's Name (First, Middle, Last) Elmer Lewis McLean	2. Date of De Month	aath Day	3. Time of De	eath A M
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. Facility Number  5. Social Security Number  6. Sex  7. Age (In yrd last birthday)  10 Under 1 Year  11 Under 24 Hrs.	)	4c. County of		
	Funeral Director	c	5. Social Security Number 6. Sex 12 M 2 F 7. Age (In yrd. last birthday) 17 Months Days Hours Min.  18 Months Days Hours Min.	8. Date of Bir	2/37	9. Birthplace (State or F Country)	oreign
	the Marylan 28a-f show notified at	Director	10a. State 10b. County 10c. City, Town or Location Bultimore			10d. Inside City I	
	within 72 hours after death with the Maryland ane. Than "netural", or Itams 23a or 28a-f show is Medled Examinar must be notithed at		10e. Street and Number  10f. Zip Code  10f. Zip Code  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Spe	anif . Van an Na	10g. Citizen of Wh	4	
920	ursafterd al', orltam Exaπinal	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Specify Cuban, Mexican, Puerto If Yes, Specify: 13. Was Decedent of Hispanic Origin? (Specify: If Yes, specify Cuban, Mexican, Puerto If Yes, Sive Year or Dates:	Rican, etc.)	Black,	American Indian, White, etc.	
21215-0036	d within 72 hour giene. ir than "natural' ire Medical Era	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working) (Iffe. DO NOT use retired)	ing	16b. Kind of Busi	ness/Industry	
N	70 To 12 TO	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name  18. Mother's Name		Maiden Surrame)	walgire	
Maryland	2 sho	ဥ ·	1 a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura		er, City or Town, St	ate, Zip Code)	2 ,
altimore,			20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	Date 104	alc. Location - Ci	ity or Town, State	_
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee  Varyer Street  4905 1 100 L	w Fri	Jeral C	ero as	
	nysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyill g, such as cardiac o shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a.   JUB-DWAL ITEMATOM	or respiratory a	rre ,	Approximate Interval Betwee Onset and Dea	
	/Medical Examiner	<u></u>	Due to (or as a consequence of):  Sequentially list conditions.  b.			5 day	
8	ate be executed hysician and the burial-transit	Examiner	The state of the s	LINL.	EXAMINER	3400	V)
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ds, P.	w requires that the de been signed by the should be detached	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to		ute to the cause of deat	
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f Vital	Physician: The this certificate al director, pag	To Be C	Diabetes, Gangrene of left foot  25. Was case referred to medical examinar 2 No		ne	Yes 212-No	
sion o	ding After fune	Certification;	27. Manner of Death  1 Statural 5 Pending investigation  28a. Date of Injury 28b. Time of Injury Work?  1 Yes 2X No F	28d. Describe h	now injury occurred	ad on bed	
Divi	pital or Attan urs after deatl aral Director: illed in by the		4  Homicide determined determined determined building, etc. (Specify)  Hospital	City or Tow Inton M	<sup>m, State)</sup> Ral emorial F	or Aural Route Number, <b>timore MD</b> lospita	
	To the Hospital ithin 24 hours a to the Funeral C completely filled i	Medical	29a. Certifier (Check only one)  1 ☐ Strifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.  29b. Signature and title of certifier  29c. License number	ed at the time,	cause(s) and mannedate and place, and 29d. Date signed (A	i due to the cause(s)	
)	0 m		Pechant Elock, & M.D. AT-2438946				ī
			20 Name and address of names who completed become of death (Itam 80a) (Time 80a)				
	Sta Registr	1	Richard E. Cook Tr. Zel E. University Blod Baltin  31. Date filed (Month, Day, Year)  32. Registrar's Signature				

			For State Registrar	State of M	arylan		artment of H rtificate of I		nd Mental Hy	/giene Reg. No. () (		28582
	Pĥysici		Decedent's Name (First, Midd FAYE				MILLHOU	ISER	2. Date of D Month SEPTEM	Day	2004	3. Time of Death 5:00 A M
	/Medid Examin		4a. Facility Name (If not institution	-			4b. City, Town, or	Location of	Death	4c. Cour	ty of Death	
			HOSPICE OF BAL  5. Social Security Number			CTR.	If Under 1 Year	TOWS		irth	BALTI	
	Funeral Director		306-42-1873	1 M 2 F	69		Months Days	Hours	Min. JUNE 2	rth av, Year) 19,1935	Cou	place (State or Foreign ntry) IN
	and		Usual Residence of Decedent  10a. State 10b. County	,	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Marylan I-f ehow Iled at	tor	MD	N/A		BALT	IMORE					1 Ves 2 □ No
	ith the M or 28a-f	Oirec	10e. Street and Number		J		10f. Zip Code			10g. Citizen o	f What Cou	intry?
	sath w	Funeral Director	23 PIERSIDE DR	IVE #322	Ever in II	C 12.1	Man December of U	21230		14 B	ace - Ameri	USA
الم 5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28a-f ehow other traumatic event, Ite Medical Examiner must be notified at	by	11. Marital Status  1 □ Never Married 2 □ Mai  3 🎇 Widowed 4 □ Divorced	rried Armed Forces?  1 ☐ Yes 2 💥	•		was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🎇 No	Specify:	n? (Specify Yes or N Puerto Rican, etc.)	Spec	ack, White,	
2.0	72 hours "naturel",	eted		nt's Education est grade completed)		(Give	dent's Usual Occup	during most of	of working	16b. Kind of	Business/Ir	ndustry
2121	within ene. then '	Completed	Elementary/Secondary (0-12)	4 College (1-4or	5+)		DO NOT use retired Y SPECIAL	*		SOCIAL	SECII	RITY ADMIN.
	be filed withital Hygiene. d other then event, It e M	Be Co	17. Father's Name (First, Middle	Last)		11,1111			s Name (First, Middle			101111111111111111111111111111111111111
⊗ 5 :O Maryland	should be filed within and Mental Hygiene. I marked other then umatic event, ILE M.	TOE	OSCAR			FORST		MYR				LABRY
B Mar	id 2 sho Ith and 27 Is ma trauma		19a. Informant's Name/Relation. PAUL MILLHOUSE				-		or Rural Route Numl 1A - BOST			*
0 .	ss 1 and of Health item 27		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·		Place of Dispo	sition (Name of natory or other place	1	Date	20c. Location		
004 Baltimore	Pages ment of tent: If it		1 ☐ Burial 2 🂢 Cremation 1 ☐ Donation 5 ☐ Other (	3 Hemoval from State		LLTOP :	SERVICE C	ORP 9	7/2004		SON,	
200 Balt	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other trau <u>once</u> .	), (),	21. Signature of Funeral Service	Licensee					SOL LEVIN N ROAD -			
•			23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final	r complications that caused t only one cause on each li	d the deat ne.	h. Do not ent	er the mode of dyin	g, such as c	ardiac or respiratory a	arrest,		Approximate Interval Between Onset and Death
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TEMB 68760,	icate be ophysicians the buri	edical		d								
SEPT Box 6	ath certi attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Feta	Ideath 3□	Ectopic pregnancy Other (specify)				ate of deliv	ery Day Year
, 0	D 0 0	hysic	1 Yes 2 No 9 Unknown	9 Unknown	t tillie or d	- SC						
✓尼 ords, P	sign sign d be	by	Part II. Other significant condit	ions contributing to death b	out not res	ulting in the u	nderlying cause give	en in Part I.		tobacco use co Yes 2 □ No		he cause of death?
FA Rec	The taw ate has b page 2 si	Completed						-	24a. Was auto perf 1 □ Yes		prior to co death?	ppsy findings available impletion of cause of
Vital	Physicien: The lathis certificate har all director, page	Be	25. Was case referred to medica examiner?	Hospital:			othe Othe		of Death (Check only	121-		
X =	di S	ion: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendi	28a. Date of Inju	ıry	28b. Time of Injury	28c. Injun Worl	4   14013		idence 6 00 how injury occi		m hospice
HOUSE Division	l or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could	not be			eet, factory, office		28f. Location	(Street and Nun wn, State)	nber or Rura	a <i>l R</i> ou <i>te Number</i> ,
MILL#OUSE Division o	Hospite 14 hours Funeral tely filled	edical C	29a. Certifier (Check only one)  Certifyi	ng Physician: To the best Examiner: On the basis of and manner st	of examina	owledge, death	n occurred at the time vestigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time	cause(s) and r date and place	nanner as s , and due to	stated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifi	ers			29c. License	s number	3	29d. Date sign		
	10		30. Name and address of person	who completed cause of o	death (Iten	n 23a) (Type,	Print)	•				
	Sta	ate.	Afron Curacu 31. Date filed (Month, Day Year		ar's Signa	ature	wes st	184201	· ~ 0	21204		
	Registi		31. Date filed (Month, Day, Year SEP	0 9 2004	de	K	Siele					

DHMH 17 Rev 1/2001 - -

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Mihalko Frances Agnes /Medical September 6, 2004 2:38 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3005 Vulcan Road Dundalk Baltimore Co. If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 XF 213-26-3555 Director Yrs. 74 March 12, 1930 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28e-f show traumatic event, if e Medical Evantinar must be notified at 10d. Inside City Limits Director 1 Yes 2 No Marvland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3005 Vulcan Road Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "naturaf", or Items 23 21222 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No þ Specify: Specify: 3 √Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Steel Elementary/Secondary (0-12) College (1-4or 5+) Fabrication Plant 11 Years Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Kolodiej Elsie Black 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Mr. Bernie Fogler / Friend 3007 Vulcan Road Dundalk, Marylard 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Park 9/9/2004 Elkridge, Maryland 21. Signature of Funeral 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. De 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Cardiac Arrest /Medical Due to (or as a consequence of): Examiner Respiratory Arrest Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events The law requires that the death certificate be executed use as the burial-transit Breast Cancer resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Brain Tumor Metastasis from Breast IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy jo Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 the 9□ Unknown 9 🗌 Unknown ģ Atter this certificate has been signed I funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by Completed Cancer Pain, Seizure 1 ☐ Yes 2X No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rmed? XXNo 1 Tes 2 No 1 Tyes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🕱 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death death. 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO DOO47157 September 9, 2004 30. Name and address of derson who completed cause of death (Item 23a) (Type, Print) Yoon Jung Kim, M.D. 1576 Merritt Blvd. Suite 14 Baltimore, Maryland 31. Date filed (Month, Day SEP **y°9** 2004 3 Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) 8,2004 **Physician** MEULMA 8-00 A /Medical Facility Name VII not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTWORE CIT topking If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
JUNE 3, 1959 9. Birthplace (State or Foreign Age (4 (In vrs. last birthday) **Funeral** Months Days Hours 151-56-8192 1 ☐ M 2 🕅 F NEW Vrs **JERSEY** Director Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show PA NORTHAMPTON 1X Yes 2 No NORTHAMPTON Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1326 ATLAS LANE 18067 USA death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Depertment of Health and Mental Hyglane. Important: If item 27 is marked other than "natural; or iten any injury or other traumatic event, Ital Medical Evant 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE If Yes, Give Year or Dates: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) OWNER HAIR SALON HAIR DRESSER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FRANK A. BUTRICO GLORIA DURSO 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) husband 1326 ATLAS LN. NORTHAMPTON, PA. 18067 MARTINUS MEULMAN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition X Burial 2 □ Cremation 3 □ Removal from State OUR LADY OF HUNGARY 09/13/2004 NORTHAMPTON, PA. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. ONICE 16924 YORK RD. MONKTON, MD. 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final poxemia **Physician** disease or condition resulting in death) /Medical large cell lymphoma Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 men 1 Yes 20 No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 No should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy 2 No 1 Yes certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes this After this funeral d 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation s after de. ral Director: Alle by the fit 1 Tyes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) n 24 hours after der ne Funeral Directo stetely filled in by the 3 🖺 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a JOHNS HOPFINS HOSPITAL, GOO NORTH WOLFE STIZEET, BALTIMORE AHRUAD, MD HOMAN 31. Date filed 32. Registrar's Signature State Registrar SEP 0 9 2004

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 6, 2004 Jewell Louise Nunley 12:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) 9. Birthplace (S Country) Oct. 16, 1915 Montana If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Months Days Hours Min Yrs. 88 Director 51**7-**12**-**9494 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland | Montgomery North Potomac Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20878 6 Quince Mill Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify:White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Medical Records Technician Healthcare other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) n and Mental permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item Z7 is marked ery injury or other treumatic ev one. Charles Henry Paugh Sadie M. Stierhof 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kay A. Levin/daughter 6 Quince Mill Court North Potomac, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 ☐ Burial 2X Cremation 3 ☐ Removal from State W. Arundel Crematory 8, 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licensie Going Home Cremation Service P.O. Box 784 ille M01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Myocardial Infarction 1 day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Hypertension; Renal Insufficiency; Asthma; Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Rheumotoid Arthritis certificate ha 1 Yes 2**X** No the Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Xnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of ceptific 29c. License number 29d. Date signed (Month, Day, Year) D26540 September 7, 2004 30. Name and address of person was completed cause of deat (Nem 20a) (Type, Print) 16220 Frederick Rd. Gaithersburg, Maryland Carl I. Schoenberger M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

SEP 0 9 2004

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Physician 10:16 P September 2, 2004 /Medical Helen Neidert 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 402 Obrecht Road Millersville 8. Date of Birth (Month, Day, Year)
DEC. 16, 1918 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 KF MARYLAND 212-20-7187 85 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Madical Examiner must be notified at 1 Tes XX No Director MARYLAND ANNE ARUNDEL MILLERSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with or Items 23a or 402 OBRECHT ROAD 21108 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 24 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify: 2 Specify: 3X Widowed 4 □ Divorced "nature!" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than ury or other treumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FREDERICK D. HEMSTETTER EDNA MAY FORD ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WILLIAM NEIDERT, JR. / SON 401 OBRECHT ROAD MILLERSVILLE, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. GLEN HAVEN MEM. PK. GLEN BURNIE, MD 4 Donation 5 Other (Specify) 21. Signal of Funeral Service Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral 421 Crain Highway S.E. Home P.A. Glen Burnie, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3heimers /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 □Unknown 1 Tes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗆 No efter death. death. 2 Accident 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) within 2 To the ţ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 men address of person who completed cause of death (Item 23a) (Type, Prin 30. Name a Lyou B 5. Crain Day, Year) State SEP 0 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Month Dav Year **Physician** 11:11 P M September 1 2004 Frederick J. Nicklas Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel 710 Old Stage Road Glen Burnie Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours Min. 112 M 2□ F Director March 5, 1925 Maryland 216-16-4660 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show traumatic evant, the Medical Examiner must be notified at 1 ☐Yes 2 No Director 28a-f s Glen Burnie Maryland Anne Arundel 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 Items 23a United States 21061 710 Old Stage Road death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 1 ☐ Never Married 2 ☐ Married 2 No Navy ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ₩idowed 4 Divorced Year or Dates: WWII White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If itam 27 is markad othar than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Bricklayer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anna D. Otto John F. Nicklas ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frederick J. Nicklas Jr. - Son 104 Cromwell Avenue, Glen Burnie, Maryland othar 20b. Place of Disposition (Name of cemetery, crematory or other place) September 4 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If it
any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State ponation 5 Other (Specify) Glen Haven Mem. Park 2004 Glen Burnie, Maryland 22. Name and Address of Facility
Kirkley-Ruddick Funeral
421 Crain Highway S.E. 21061 vre of Funeral Servi Home P.A. Glen Burnie, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician Gho years disease or condition resulting in death) /Medical Due to (or as a **Examiner** 70 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed 001 as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day ğ in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe 1 Yes 2 No 3 Probably 4 nknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No certificate 2 1 No 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient Ţ 1 Tyes 2 NO 3 DOA his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 TYes 2 No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely within 2 To tha 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed e, 1600 32. Registrar's Signature 31. Date filed (Month, Day, Year) 9 2004 Registrar

22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122 Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 DEctopic pregnancy Month Year Day

sign be ( page 2 a

P.O. I

Records.

Division of Vital

To the Hospitel or Attending Physicien:

within 24 hours a To the Funerel D illed 23b. Was decedent pregnant 25. Was case referred to medical

Physician/Medical Be Completed by Certification: To 27. Manner of Death s after oc.

in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

examiner'

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Momicide

(Check only

1X Yes 2 □ No

28a. Date of Injury **Formati**. Day Year)

9/3/04

Scene

4☐Pregnant at time of death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

5 Other (specify)

23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes

2. Date of Death

8. Date of Birth (Month, Day, Year)

June 21 1982

Month

Day

SEPTEMBER 3.

Year

ANNE ARUNDEL

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

Retail

Bracci

20c. Location - City or Town, State

Davidsonville MD

USA

14. Race - American Indian, Black, White, etc.

white

2004

3. Time of Death

8:09a

10d. Inside City Limits

1 ☐ Yes 2X No

Birthplace (State or Foreign Country)

Maryland

2 No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 X Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No

26. Place of Death (Check only one) Cther: 4 Nursing Home \*\*\* Nursing Home \*

2X No

28d. Describe how injury occurred

Unknown

28f. Location (Street and Number or Bural Soute Number City or Town, State) 1501 Harlboro Ct.

Crofton, Md

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier

5 🖺 Pending

investigation

6 Could not be determined

28b. Time of

Found

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number OCME

28c. Injury at Work?

🖂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year) SEPTEMBER 3, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Southers, m.D.

Yamela E. 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Medical

SEP 0 9 2004

			1 _ State	State of Maryland / Department of Health and Certificate of Death		2001 20500
2	(\$)		Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death Month	3. Time of Death
1	Physicia /Medic	al	Iheodore  4a. Facility Name (If not institution, give st	tar Ker  (reet and number) 4b. City, Town, or Location of D	Septemb	er 4,2004 0429 M
	Examin	er .	Bon Secoul	35 Hospital Baltimo	re	NA
(d).344	Funeral Director		X12-36-7009 /	M 2 F 7. Age (In rs. last birthday) If Under 1 Year If Under 24 1  Yrs. Months Days Hours N	Hrs. 8. Date of Birth Min. (Month, Day, Yes	9. Birthplace (State or Foreign Nountry) 438 Mary and
	yland	}	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Location	,	10d. Inside City Limits
	ith the Marylar or 28a-f show	ector	Maryland N/A	Baltmore	100	1 1 Yes 2 □ No Citizen of What Country?
	23a or 2	Funeral Director	1929 Vine	S+ 2/223	log. (	USA
	items	uner	11. Marital Status 1. Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No	(Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	s filed within 72 hours after death with the Maryland Il Hygiene. other than "natural", or Items 23e or 28e-f show vent, the Medical Ever-instruct the notified at	by	3 Widowed 4 Divorced	If Yes, Give 1 Yes 2 X No Specify: Year or Dates:		specify: Black
15-0	in 72 h "natu Audisul	Completed	15. Decedent's Educi (Specify only highest grade	completed) (Give kind of work done during most of life. DO, NOT use retired)	working 16b.	Kind of Business/Industry
2121	filed with Hygiene other tha	Com	Elementary/Secondary (0-12)	college (1-40r5+) Laborer		rivate tirm
Maryland	should be fill and Mental H marked ott umatic even	To Be	17. Father's Name (First, Middle, Last)	rker Aug	Name (First, Middle, Maid	on Sumamo)
lary	2 shou and M is mar sumat	-	19a. Informant's Name/Relationship (Typ	19b. Mailing Address (Street and Number of	Rural Route Number, City	y or Town, State, Zip Code)
	s 1 and if Health item 27 other tr		20a. Method of Disposition	20b. Place of Disposition (Name of	Date 20c.	Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importance of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any lojury or other traumatic event, the Madical Exact in at mail to a collidat at any lojury or other traumatic event, the Madical Exact is at mail to a collidat at any logue.		1  Burial 2  □ Cremation 3  □ Re  4  □ Donation 5  □ Other (Specify)	Mt Carmel	18/2004 D	undalk, Md.
Balt	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licens-	22. Name and Address of Facility Joseph L. Russ 2222 W. North	s Funeral Ave. Bal	Home. 21216
			shock, or heart failure. List only one	eations that caused the death. Do not enter the mode of dying, such as care e caus on each line.	diac or respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	yoular De	sease -
	Examiner		Sequentially list conditions. b.	Hypertension Dusto for as a consequence of):		
V	d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Peril Vosculer Dis	موم	
, 09	cate be executer physician and s the burial-transit		resulting in death) Last	Due to (1 r as a consequence of):		
68760	g physi as the I	ledicai	d.			
Вох	death certific e attending pl d for use as t	Physician/Med	in the past 12 months?	3c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
P.0.	at the de by the a	hysi	1 Yes 2 No 9 Unknown	9□ Unknown		
ecords,	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions conf	tributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?  2 No 3 Probably 4 Striknown
leco	e law requ has been ye 2 should	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital B	T ate	e Cor	25. Was case referred to medical	26 Place of	1 Yes 221	
of Vi	ding Physician: h. After this certific funeral director,	To B	examiner? 1 🗆 Yes 2 🗖 No Ho	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursin	ng Home 5 Residence	6 □Other (Specify)
ono	Jing After fune	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred
Division of	il or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Co	29a. Certifier 1 Certifying Phys. (Check only one)	ician: To the best of my knowledge, death occurred at the time, date and ples: On the basis of examination and/or investigation, in my opinion, death o and manner stated.	ace, and due to the cause occurred at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
•			I hogal At	MD 047405	9	18/04 MD2/20/
	7		30. Name and address of person who con	mpleted cause of death (Item 23a) (Type, Print)  1	Baltemas	MD2/20/
066	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature		

	,	1	1- For AMEND ITEM #1State of Maryland / Depart 1- State Registrar AMEND ITEM #20b PER FH C835 940	tment of Health and Mental Hygi Jugae of Death	iene 9 NG 004 28590		
g.	Physicia	in	1. Decedent's Name (First, Middle, Last) Herbert Lester Powell	2. Date of Death Month Sept. 6	h Day Year 3. Time of Death		
	/Medic Examin	er		4b. City, Town, or Location of Death Randallstown	4c. County of Death Baltimore		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day, Dec. 2,	Year) 9. Birthplace (State or Foreign Country) 1930 Maryland		
	anyland show	'n	Usual Residence of Decedent  10a. State  10b. County  Maryland  N/A  Baltimo		10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
	with the M t or 28a-f	Directo	10e. Street and Number	10f. Zip Code 10	Og. Citizen of What Country? USA		
936	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. item 27 is marked other then "neturel; or Items 23s or 28s-f show other treumatic event, Ite Medical Establish matter relified.	by Funeral Director	1 Never Married 2 Married 1 Yes 2 X No	as Decedent of Hispanic Origin? (Specify Yes or No- res, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2X No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black		
21215-0036	ed within 72 hoi ygiene. ier then "neturi t, I'm Medicell	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  8th grade  (Give kii life. DC  Labo	nd of work done during most of working O NOT use retired) O YET	16b. Kind of Business/Industry		
Maryland	2 should be filed with and Mental Hygiene. is marked other ther eumatic event, Tech	To Be	17. Father's Name (First, Middle, Last) Charles Powell	18. Mother's Name (First, Middle, M Nettie	Maiden Surname)		
	1 and 2 sho Health and I Iem 27 is ma	-	10 Informantia Nama/Balatianship (Type Print) 19h Mailing	Address (Street and Number or Rural Route Number, Dovedale Road Randal	lstown, Maryland 21133		
Baltimore,	permit. Pages 1 an Department of Heal Importent: if item 2 eny injury or other once.		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	ny Cross of No Composition (Name of No Composition) 9/11/04	BALTO MD BALTO MD midalk, Mary land		
Balti	permit. Pages Department of Importent: If it eny injury or c once.			Name and Address of Facility Chatman-H 40 Reisterstown Rd Ba			
	Pnysician		23a. Part 1. Inter the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition		est, Approximate Interval Between Onset and Death		
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
8760,	certificate be executed rding physician and Ise as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):				
O. Box 6	death certific e attending p d for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ictopic pregnancy Other (s <i>pecify</i> )	23d. Date of delivery Month Day Year		
ds, P.	w requires that the states that the states that the should be detached			, and a second s	pacco use contribute to the cause of death?		
Division of Vital Records,	sicien: The law requ certificate has been irector, page 2 shouli	Completed by		24a. Was a autops perform 1 □ Yes 2	y prior to completion of cause of		
Vital	Physicien: this certifica	o Be C	25. Was case referred to medical examiner?	26. Place of Death (Check only on			
ion of	ng Phy Iter this Ineral d	-	100 0 11	A Comment of the Comm	ow injury occurred		
Divis	al or Atte s after dea al Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street building, etc. (Specify)	et, factory, office 28f. Location (St. City or Town	reet and Number or Rural Route Number, n, State)		
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death 2 Medical Exeminer: On the basis of examination and/or investant and manner stated.	occurred at the time, date and place, and due to the constigation, in my opinion, death occurred at the time, do	ause(s) and manner as stated. ate and place, and due to the cause(s)		
	To th To th	Σ	29b. Signature and title of certifier		9d. Date signed (Month, Day, Year)		
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, P	DIN59107 C FIND LIBERTY GRAP BATIMEE	Y HEIGHTS OVERWE		
	*\		KALV UMA WESTEDE MEDICAL  31. Date filed (Month, Day, Year)  32. Pigistrar's Signature	GRAM BATIMARE	mo 121245		
	Sta Regist	ate rar	0== 0 0 2004 K	and a			

Physic	ian	1. Decedent's Name (First, Middle, Last				2. Date of De Month		3. Time of Death
/Med		Alexander Euge				Septeml	ber 8 200	04 1:37p M
Exami	ner	4a. Facility Name (If not institution, give	·		r Location of Death		4c. County of	
Funeral		Carroll Hospita  5. Social Security Number 6. Sec		Westmin	If Under 24 Hrs.	8. Date of Bir	th Carro	Birthplace (State or Foreign
Director		5. Social Security Number 214-20-1186	M 2□F 92 Yrs.	Months Days	Hours Min.	(Month, Da April 1	ly, Year)	Country)
pu *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ageting				
Aaryle F sho	ō	Md Carroll	Sykesvil					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
288-	rect	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	t Country?
h with 23a o	al Di	5937 Snowdens Run	Road	21784			USA	,
permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at any injury or other treumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status	Armed Forces?	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		American Indian, White, etc.
s afte	by Fu	1 Never Married 2 Married	1 ⊕Yes 2 □ No 1944-	1□Yes 2□No	Specify:	Tildani Stary	Specify: V	
hour turel	ed b	3 ☐Widowed 4 ☐ Divorced  15. Decedent's Edu	rear or Dates: 19240	A dent's Usual Occup	ation		16b. Kind of Busin	
nin 72 n "ne nadic	plet	(Specify only highest grad	e completed) (Give		during most of work	ing		•
d with giene ar tha	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) +2 supe:	rvisor		i	steel fal	rication
al Hy	Be	17. Father's Name (First, Middle, Last)					, Maiden Sumame)	
Ment Ment arked	P	Sam Popien			Helen Mo			
12 sh h and 7 is rr treum		19a. Informant's Name/Relationship (T)					er, City or Town, Sta	te, Zip Code)
1 and Healt em 2	1	Alfred O. Popien 20a Method of Disposition	(SOII) 4839 20b. Place of Dispo		., Sykest	ZIIIE, M	20c. Location - City	or Town State
ages ant of it: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	Tolo Via			-04	Sykesvill	
artme orten injur		21. Signature of Funeral Service Licens			i		neral Home	
Depar Impo		byan 6.9			95 Sykesy			d Chaper
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death. Do not ent	er the mode of dyir	ig, such as cardiac			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	SEPSIS UNDEFERU	lived Eti	olasu			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence of):	, (	1			10
LXummer	100	Buquentially list conditions,	Due to () as a consequence of):	t vzulur	٩			> 1 month
nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bus to (7 as a consequence or).					
execun and ial-tra	Exai	that initiated events resulting in death) Last	Due to (or as a consequence of):					
death certiticate be executed e attending physician and of tor use as the burial-transit	dicai		d				_	
rtifica ng ph as th	Medi	IF FEMALE:						
eath certiti attending   tor use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy	,		23d. Date of Month	•
	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 5□ 9□Unknown	Other (specify)			Month	Day Year
The law requires that the diate has been signed by the bage 2 should be detached	Ph		ntributing to death but not resulting in the u	nderiving cause giv	en in Part I	23e. Did to	obacco use contribut	te to the cause of death?
uires tha signed Id be del	d by		,					Probably 4 @Onknown
w requir been si should	Completed					24a. Was	an 24h Wer	autopsy findings available
The lav	omp					autop perfo	prior deat	to completion of cause of
	0	25. Was case referred to medical			26. Place of Deat		2 <b>- N</b> o 1 - 1	Yes 2⊞No
Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	fospital: 1 Inpatient 2 ER/Outpatier	nt 3□ DOA Oth	on		dence 6 Other (S	Specify)
ng Pł tter th ineral	ü.	27. Mann of Death 1 atural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injun World	y at k?	28d. Describe h	now injury occurred	
uttendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 □ No			
l or At after c Direc i in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office		28f. Location (5 City or Tox		r Rural Route Number,
spital ours a nerel tilled		29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge, death	occurred at the tin	ne, date and place	and due to the	Cause(s) and manno	r as stated
Fur tely	edicai	(Check only 2 Medical Exami	On the basis of examination and/or in and manner stated.	vestigation, in my o	pinion, death occurr	ed at the time,	date and place, and	due to the cause(s)
0 0 0	Me	29b. Signature and title of certifier		29c. Licens	a number	:	29d. Date signed (M	onth, Day, Year)
To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: Atter this certific completely tilled in by the funeral director,		121.11/11/11/11	1-0	1)-	102191		9/2/04	<b>'</b>
X		fallen june	T4)	1 0	0006		110101	
To the within 2 To the comple		30. Name and address of person who co	propleted cause of death (Item 23a) (Type,	Print)	0806	01	T. N-26	Proc 100

Albert Radomile 04-05 RPD

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

5743		Unpend Item	State of N	<b>per</b> I				d Mental H	ygiene	9		
		State Registrar  1. Decedent's Name (First, Middle, Las	t)		Ce	rtificate of	Death	2. Date of D	Reg. No	<del>hal-</del>	3. Time of Death	_
Physicia		Albert Radomile	•/					Month	Da	y 4, 2004	915 A M	Α
/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death									723 21	_
		Peninsula Regiona				Salisbu	-4	U-a I		Wicomico		
Funeral Director		5. Social Security Number 6. Sec. 203–44–2389	X ZM 2□F	Age <i>(I</i> n <i>yr</i> s. <i>1</i>	ast birthday) Yrs.	Months Days	Hours N	Min. 8. Date of B (Month, D Aug.	av, Year)	9. Birth Cour	place <i>(State or Foreig</i> i n <i>try)</i> 18y1vania	n
po >		Usual Residence of Decedent  10a. State 10b. County			, Town or Lo				-, -,			_
Manyla f sho	ō	Delaware Sussex									10d. Inside City Limits 1 ☐ Yes 2 X No	
r 28e	Directo	10e. Street and Number		Ken	oboth	10f. Zip Code			10g. Cit	tizen of What Cour	ntry?	
23a o	ai D	1 Gary Avenue				19971			USA			
lore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23a or 28e-f show or other treumatic event. It a Madical Examinational be notified at	by Funerai	11. Marital Status  1   Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date:	ş? ÜNo		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin' an, Mexican, P Specify:	? (Specify Yes or N uerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: Whit	etc.	
2 hou	ted	15. Decedent's Ed	ucation		16a. Dece	dent's Usual Occup	ation		16b. K	will L ind of Business/In	dustry	
within 7	Completed by	(Specify only highest gra-	College (1-4c	or 5+)		kind of work done DO NOT use retired	during most of 1)	working				
Hygier ther there	CO	17. Father's Name (First, Middle, Last)	4		Sales	man	18. Mother's	Name (First, Middle		ce Compa	ny	_
Taryland 2121 2 should be filed within and Mental Hygiene. is marked other than eumatic event. If a Mental and a mente event.	To Be	Geno Radomile					Del Co	•	o, maiden	Junamey		
ary shou and M s mar	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address (Street	and Number o	r Rural Route Numi	ber, City o	or Town, State, Zip	Code)	
and		William J. Raucci,	partner	an D				oth Beach	-			_
Baltimore, Maryland 21215-0036 semit. Pages I and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. mportent: if item 27 is marked other than "naturel; or any injury or other treumatic event. Ite Madical Engin		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specify	)	10	Arunde	sition (Name of matory or other place 1 Cremato	ry 7	ptember , 2004		nton, Ma		
Baltimo permit. Page Department of Importent: if eny injury or		21. Signature of Funeral Bervice Licen  Bevery L. H.	tto	MO1:	Go 251 Be	Name and Addressing Home verly L.	ss of Facility Cremat Heckro	ion Servi tte, P.A.	.ce Cla	P.O. Box rksville	784 MD 21029	9
ate be nysicia he bur	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	ensive as a consequ as a consequ as a consequ	uence of):	rosclerot	ic Care	diovascul	ar D	isease	Onset and Death	
death certiff death certiff e attending d for use as	Physician/Med	in the past 12 months?	23c. If yes, outcon 1 Live birth 4 Pregnant	2 Fetal at time of de	death 3	Ectopic pregnancy Other (specify)				23d. Date of delive Month	ery Day Year	
S, es ti	۵	9 □ Unknown Part II. Other significant conditions co	entributing to death	but not resu	ulting in the u	nderlying cause give	en in Part I.			use contribute to th	he cause of death?	1
I HeC The law ate has b	Completed							24a. Was		prior to cor death?	psy findings available mpletion of cause of	)
VIT&	Be	25. Was case referred to medical examiner?	Hospital:			Oth		Death (Check only				
hys hys	. To	1  Yes 2 No 27. Manner of Death	i l ∐inpa		ER/Outpatien 28b. Time of		4 🗆 IAUISIII	g Home 5 Res 28d. Describe			/)	_
Vite funery the funery	atior	1 ANatural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, L	Day Year)	Injury	Worl	<br Yes 2 □ No		, , , , , , , , , , , , , , , , , , , ,	, 555455		
DIVISION  tel or Attending s after death. al Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At ho etc. (Specify	me, farm, str	eet, factory, office		28f. Location ( City or To		d Number or Rura )	i Route Number,	
Hospi 4 hou Funer ely fill	edicai	29a. Certifier 1 Certifying Phyone Check only one)	vsician: To the be- iner: On the basis and manner	of examinat	wledge, death ion and/or inv	occurred at the time restigation, in my of	ne, date and pl pinion, death o	ace, and due to the	cause(s) date and	and manner as st place, and due to	ated. the cause(s)	
To the within 2 To the complet	Σ	29b. Signature and title of certifier	re You	le v	w	29c. License				e signed (Month, i		
		30. Name and address of person who of	1. 1CORE	CC		Print) 111 Penn	Street	, Baltimo	re, N	Maryland	21201	
Stat Registra	7 11	31. Date filed (Month, September 9)		rar's Signat			_					
DHMH 17 Rev 1/20			7			Span	6					_

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State of Maryland	/ Department of Health	and Mental Hyg

		For State Registrar	State of Maryla		artment of Health			ene LNQ () () ()	20502
Physic	ian	Decedent's Name (First, Middle, Last)	Herman		ush		2. Date of Death Month	Day Year	3. Time of Death 5:13 A M
/Medi Exami		4a. Facility Name (If not institution, give str			4b. City, Town, or Location		Septembe	2004 4c. County of Deat	
CAGIIII	ic.	William Hill Nursi			Easton				Talbot
Funeral		5. Social Security Number 6. Sex 1521	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year If Under Months Days Hours	Min.	B. Date of Birth (Month, Day, Y	'ear) Co	hplace (State or Foreign untry)
Director		Usual Residence of Decedent	92			1	May 9,1	912 P	ennsylvania
nyland how		10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
Ba-f	Director	Maryland Caroline	co.		Presto	on			1 ☐ Yes 2 ☑ No
with the or 2	Dire	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	
"netural", or Items 23e or 28e-1 ehow	Funeral	21112 Skeleton Cr	2. Was Decedent Ever in	U.S. 13.1	Was Decedent of Hispanic Of If Yes, specify Cuban, Mexico	21655 Origin? (Spec	ify Yes or No-	United 14. Race - Ame	rican Indian,
or Iter	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		lf Yes, specify Cuban, Mexica 1 ☐ Yes 2 <b>%</b> No <i>Specif</i> h		ican, etc.)	Black, White	
ural',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:			у.			White
n 72 h	ojete	15. Decedent's Educa (Specify only highest grade	completed)	(Give	dent's Usual Occupation kind of work done during mo DO NOT use retired)	ost of working	g 16	6b. Kind of Business/	Industry
d withing in the man	Completed	Elementary/Secondary (0-12) 5 Years	College (1-4or 5+)		Electrician			Steel In	dustry
be filed within 72 hours after death with the Maryland la! Hygiene. Id other then "natural", or items 23a or 28a-1 ehow event, the Modical Examinar must be notified at	BeC	17. Father's Name (First, Middle, Last)					(First, Middle, Ma	aiden Sumame)	
2 should be filed within and Mental Hygiene.	10	Judson Rush					Nedrow		
s 1 and 2 should be filed within 72 hc I Health and Mental Hygiene. Item 27 ie marked other then "natur other traumatic event, the Mudical		19a. Informant's Name/Relationship (Type		1	ng Address (Street and Numi				Zip Code) 2 <b>1</b> 655
1 and Health Hem 27		Mr. William A. Rus 20a Method of Disposition		Place of Dispo	2 Skeleton Cr	Da	-	oc. Location - City or	
Pages nent of l		1 Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)			Tatory or other place)	ant 0	2004	Baltimore	, Maryland
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any njury or other tra		21. Signature of Funeral Service Licenses		. 22	2. Name and Address of Faci	ility			
		Justo a lo	2	1 7	ida-Ruck Funer 922 Wise Ave.	Dune	dalk, Ma	ryland 21	222
		23a. Pent1. Enter the disease, or emplications shock, or heart failure. List only one	ations that caused the de cause on each line.	ath. Do not ent	er the mode of dying, such a	s cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Salen	Spen	· Orebrova	reila	alcu	el	Mercuf
Examiner			Due to for as a conse	equence or):	war Deser	oweth	melloto	strates	100
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):			-	1 0,1	13
ecuter and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to /or on a come						
cate be executed by sician and the burial-transit			Due to (or as a conse	equence or).					
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edicai	d.							
w requires that the death certific been signed by the attending the beautied be detached for use as	Physician/Me	230. Was decedent pregnant	c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy			23d. Date of del	ivery
e deal	Sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown		Other (specify)			Month	Day Year
hat th ad by detach		Part II. Other significant conditions cont	ributing to death but not re	esulting in the u	nderlying cause given in Part	t I.	23a. Did toba	cco use contribute to	the cause of death?
w requires to be a signer sign	Completed by	arteriorbiotec 10	least Designe	with	Stud Tibula	ten			obably 4 🖄 Niknown
w req	lete	Diobetes Mell,	tus				24a. Was an	24b. Were au	itopsy findings available
The la	E						autopsy performs	ed?   death?	completion of cause of
	Be C	25. Was case referred to medical examiner?			26. Pla	ce of Death	(Check only one		
Physician: Physician: rthis certific ral director.	2	1 ☐ Yes 2 No		☐ ER/Outpatier				ce 6 Other (Spe	cify)
ding P	lon	27. Manner of Death  1. Suatural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. injury at Work?  M 1 Yes 2		8d. Describe how	injury occurred	
or Attending after death. Director: Afte in by the fune	ertification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, st			Bf. Location (Stre	et and Number or Ru	ural Route Number,
s after s after bed in t	Certi	4  Homicide determined	building, etc. (Spe	cify)			City or Town,	State)	
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.		(Check only 2 Medical Examin	er: On the basis of exami	nowledge, deat	h occurred at the time, date a	and place, ar	nd due to the cau d at the time, dat	ise(s) and manner as e and place, and due	stated.
To the Hos within 24 h To the Fur completely	Medicai	one)  29b. Signature and title of certifier	and manner stated.		29c. License number			d. Date signed (Mont.	
F 8 7 8	1	) Wellan	Haland	) Drie	•	715	-	9/5/	W/
610		30. Name and address of person who con	npleted cause of death (It	em 23a) (Type.				1-1	7
2		William Wood, M.T	501 Dutc	hman's		Mary	land 21	601	
St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	oili				

5	1	•	1 - For Unpend State Registrar	Item	238tat7,02	Manylan	sk/Mepe Ce	38319n rtificat	9-02-94 e of L	e@#h	ans! N		Reg. No		20	501
	Physici	an	1. Decedent's Name (Firs		ROMAN							2. Date of De Month	Day	Year		ime of Death
	/Media	cal -	4a. Facility Name (If not in			horl		4h City	Town or	Location	of Death	Septem		ounty of Deal		342 p <sup>M</sup>
	Examir	ier	Johns Hop			561)				more	or Douth		10.0	ounty of Boa		
52	Funeral Director		5. Social Security Number 144-58-7354	6.		7. Age (In yrs. 34	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da 7/29/19	th y, Year) <b>20</b>	9. Bir Co <b>NE</b>	hplace (Sountry)  JEF	State or Foreign
5	and	1	Usual Residence of Dece 10a. State 10b.		UNKNOWN	10c. Cit	y, Town or Lo	ocation	IINKI	NOWN					10d. Ins	ide City Limits
	Marylan f show	ğ	MD		ONRIOWI				OTITE						1 [	]Yes 2∭CXNo
	ith with the Maryla 23a or 28a-f shor	ō	10e. Street and Number	UNKNO	WN			10f. Zip	Code	UNK	MOM	ı		of What Co	ountry?	· · · · ·
21215-0036	filed within 72 hours after death with the Maryland Hygiene. stherthen "natural", or Items 23a or 28a-f show ent, the Medical Evarring Indiation wither at	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4 D		12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Da	ces? XXNo	1	Was Deced If Yes, spec				pecify Yes or No Rican, etc.)		Race - Ame Black, White pecify: W		ian,
5-0	72 ho natur	eted	15. E (Specify on	ecedent's l	Education rade completed)		16a. Dece (Give	dent's Usu kind of wo DO NOT u	al Occupa	ation during mos	t of work	ing	16b. Kind	of Business	Industry	
121	d within 7 giene. r than "n	Completed	Elementary/Secondary	(0-12)	College (1-	4or 5+)		DO NOT U ACKIN		)			WAT	REHOUS	R	
	filed v Hygie other 1		17. Father's Name (First,	Middle, Las	st)		1 1	TOKIN		18. Mothe	ər's Nam	e (First, Middle,				
lan	ould be Mental arkad c	o Be	ROMAN RO	SENDO					i	S	ANTO	OS IDALI	A			
Maryland	and h		19a. Informant's Name/F	lelationship	(Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rui	ral Route Numbe	er, City or T	Town, State,	Zip Code)	
	C = 01 -		NORA NIEVES		os	lank s				AGUAS		ENOS, PU			_	
Baltimore,	Se to L		20a. Method of Disposition  XX Burial 2 □ Cre	mation 🕉		tate	Place of Dispo cemetery, crea	matory or o	ther plac			Oate CNOWN		tion - City or		
ti m	permit. Page Department Important: If any injury o		'4 □ Donation 5 □ 0	Other (Spec Service Lie	eify)	M	UNICIPA				by MA	RYLAND		AS BUE		
Ba	perm Depa Impo any i		WALL MARIE	Econ	72-6	W01.100						S., GLE				
	Physician /Medical		23a. Paril. Enter the dis shock, or heart faul Immediate Cause (Final disease or condition resulting in Jeath)	ease or co ire List pni	mplications that ca y one cause on ea a. <b>Therma</b>	used the deat ich line.  1 Inju	ries w	ter the mod	le of dyin	g, such as	cardiac			-	Appro	eximate al Between and Death
3760,	ate be executed wax invision and he burial-transit	icai Examiner	Sequentially list condition if any, leading to immediate the frame of the condition of the	ns, ate	c	or as a conseq or as a conseq										
P.O. Box 68	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  Lo the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent preg in the past 12 mont! 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			nth 2 ☐ Feta ant at time of c	al death 3[	⊒Ectopic p ⊒ Other (sp					23	d. Date of de Month	ivery Day	Year
	uires that the signed by	by	Part II. Other significant	conditions	contributing to de	ath but not res	sulting in the u	inderlying o	ause give	en in Part I				contribute to		se of death?
al Records,	ding Physician: The law require h. After this certificate has been si funeral director, page 2 should b	Completed												24b. Were at prior to death?	itopsy find completio	dings available n of cause of
∨ital ×	sician: Th certificate irector, pag	o Be	25. Was case referred to examiner? 1 X Yes 2 No	medical	Hospital:	patient 2	] ER/Outpatie		Othe	200		th <i>(Check only o</i> ome 5□ Resi		704 12	n(4 s)	
of	g Physicar this neral dii	H- 1	27. Manner of Death			f Injury n, Day Year)	28b. Time o		28c. Injun Work	4 🗀 140	arsing Ho	28d. Describe			сну)	
ion	ittanding death. stor: Afte / the fune	atio	2 Accident	Pending investigation	on 8-23-		12:30	<b>A</b> M		<br Yes 2 <b>X</b> □	No	Unknow	n			
Division of	ial or Atta s after der al Diracto ed in by th	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not determine	28e. Place buildin At ho	of Injury - At h ig, etc. <i>(Specil</i> <b>)me</b>	ome, farm, st	reet, factor	y, office			28f. Location ( City or Tox York, Pa		<b>™728</b> °5	iral New	vberry S
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical (	29a. Certifier 1 (Check only 2 )	Certifying I Medical Ex	Physician: To the aminer: On the ba and mann	sis of examina	owledge, deat ation and/or in	vestigation	, in my o	oinion, dea	nd place,	and due to the	cause(s) ar date and p	lace, and due	to the ca	
	Tot withi	×	29b. Signature and title of	of cortiller	-Ps	Sla	L 14	1	c. License	number				signed (Mont ember		
-	1 plan		30 Name and address of	Aro	NICA-F	OLLAK	MI		1 Pe	nn St	ree	t, Balti	imore,	, Mary	land	21201
	St Regist	ate rar	31. Date filed (Month, Da		Birene 32. Re	egistrar's Signa	Annel									

		1 _ State	•	epartment of Health and Certificate of Death		ACOL ACEAE
		Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of Death	Reg.	No. 1 3. Time of Death
Physic	cian	VICTORIA	В.	CHEVENCON		Day Year
/Med Exam		4a. Fecility Name (If not institution, give st		STEVENSON  4b. City, Town, or Location of Dec		2004 10:00A *** 4c. County of Death
LAdiii	litei	4120 BEDFORD	ROAD	VILLA NOV	Δ	BALTIMORE
Funera	ı	5. Social Security Number 6. Sex	7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24 H	s. 8. Date of Birth	9. Birthplace (State or Foreign
Directo	r	219-16-5071	M 21XF 96	rs.	12/15/1	TIT DOG TATE A
pug *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
fanyle r sho	ō	MD BALTIM		ILLA NOVA		1 □ Yes 2 No
ith the Marylar or 28e-f show	ect	10e. Street and Number	JRE V.	10f. Zip Code	10g.	Citizen of What Country?
3e or	D	4120 BEDFORD RO		21207		
death with the Maryland rms 23e or 28e-f show rmust be rudiffed at	Funeral Director		2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		14. Race - American Indian, Black, White, etc.
after or Ita	Ξ	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	ato rican, etc.,	
13-UUSO 72 hours after death w "netural; or Items 23e	d by	3 → Widowed 4 □ Divorced	Year or Dates:			Specify: BLACK
net	Completed	15. Decedent's Educ (Specify only highest grade		Decedent's Usual Occupation (Give kind of work done during most of w life. DO NDT use retired)	orking 16b	, Kind of Business/Industry
within ene.	J m	Elementary/Secondary (0-12)	College (1-4or 5+)	·		WN HOME
Hygined Hygined	Ö	10TH 17. Father's Name (First, Middle, Last)		DOMESTIC 18. Mother's N	ame (First, Middle, Maid	
should be not Mental marked commerce or	To B	AUGUSTUS B	YRD	PIN	KY WEST	
Z shou and M ls mar le mar	-	19a. Informant's Name/Relationship (Typ	e, Print) 19b.	Mailing Address (Street and Number or		ty or Town, State, Zip Code)
re, Maryles s 1 and 2 should f Health and Mor item 27 is marke other treumetic		MARION R. STAR		4120 BEDFORD B	D. BALTIM	ORE MD 21207 Location - City or Town, State
		20a. Method of Disposition	comoton	Disposition (Name of y, crematory or other place)	Date 200	Location - City or Town, State
baltimor permit. Pages Department of importent: If it any injury or of		Donation 5 ☐ Other (Specify)	MD NA		11/04 LA	UREL, MARYLAND
Dall permit Depart Impor		21. Signature of Funeral Septice Icenso				NERAL HOME 21207
00740	× ×	remot Kil	Emy of	4600 LIBERTY HO		BALTIMORE, MD Approximate
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cause on each line.			Interval Between Onset and Death
Pnysiciar /Medica	_	tmmediate Cause (Final disease or condition resulting in death)		men END ST	1105	1 year
Examine			Due to (or as a per sequence of	7):		
Land of	e e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	of):		
cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
bu, be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequence of	of):		
vequires that the death certificate be expensioned by the attending physician should be detached for use as the burial	dicai	d.				
OX 08/ certificate oding phys	Med	IF FEMALE:	16			
death ceide attendir	hysician/Me	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery  Month Day Year
ched ched	ysic	1 Yes 2 No 9 Unknown	9 Unknown	3 🗆 Other (specify)		
ords, F.C requires that the een signed by th nould be detache	0	Part II. Other significant conditions conf	ributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
rdS, quires t n signe	ed by				1 ☐ Yes	2 No 3 Probably 4 Unknown
ecord law requir. as been si 2 should l	ompieted				24a. Was an	24b. Were autopsy findings available
<b>~</b> o <u>c</u> o	E O				autopsy performed	
VICAL FINE INCIDENT The Certificate rector, pag	Se C	25. Was case referred to medical		26. Place of C	eath (Check only one)	y
F SIC	To B	examiner?	ospital: 1  Inpatient 2 ER/Ou	tpatient 3 DOA Other: 4 Nursing	Home 5 Sesidence	e 6 □Other (Specify)
n OT ng Phy fter this		27. Manner of Death  1 Stural 5 Pending		ime of 28c. Injury at Work?	28d. D scribe how i	njury occurred
SIO tendi leath. for: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	206 Leastine (Ctree	Acad Number of Guest Garde Number
UNISION Or Attending after death. Director: Afte	Certification:	4 Homicide determined	28e. Place of tniury - At home, fa building, etc. (Specify)	rm, street, ractory, office	City or Town, S	t and Number or Rural Route Number, tate)
pitel cours a cours a		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge	, death occurred at the time, date and pla	ce, and due to the caus	e(s) and manner as stated.
DIVISION O To the Hospitel or Attending PI within 24 hours after death. To the Funerel Director: Attenti completely filled in by the funeral	edical	(Check only 2 Medical Examin	er: On the basis of examination and and manner stated.	d/or investigation, in my opinion, death or	curred at the time, date	and place, and due to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	0	29c. License number	29d.	Date signed (Month, Day, Year)
,		MAK	meella	11) 018868		458-6
6		30. Name and address of person who con		Type, Print)	E WALLA	IN NUMBER 21
`			D COOR	1 16 0 36	13 NO 17 17 C	12 roman ul
	itate strar	31. Date filed (Month, Day, Year)	32. Register's Signature	4 South		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 950 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death **Physician** ්ර් 3:20 R 2004 livam /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death County of Deat Examiner AAMC mapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Min 1 □ M 2 🕽 F 59 Yrs. 220-42-0259 NOV Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b Counts 10d. Inside City Limits in than "neturel", or items 23e or 28e-f show the Madical Examiner must be notified at 1 XYes 2 ☐ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 USA Completed by Funeral 1285 Graff Ct. Apt. \_1C 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify. 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Domestic 12 other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be find Mental H Francis Coleman Amelia DiMarreo 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Health Robert Hoke/son 8631 Ashby Ct. Marshall, VA 20115 20a. Method of Disposition
1 ☐ Burial 2 🖸 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 0 Department of Importent: If eny injury or sonce. Metro Crematory, Inc. 9/8/04

22. Name and Address of Facility
Cremation Society of Maryland, Inc. 9/8/04 Baltimore, MD \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 27. Signature of Facility
27. Name and Address of Facility
27. Name and Address of Facility
27. Name and Address of Facility
28. Name and Address of Facility
29. Name and Address of Facility
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20. Name and Address of Facility
29. Name and Address of Facility
20. Name and A 299 Frederick Road Baltimore, MD 21228

Approximate Interval Between Onset and Death Immediate Cause (Final Physician sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 2[] No 1 Yes 1 ☐ Yes 2 1 No or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Certification: To After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Alatural 5 Pending death, 1 Tes 2 No investigation 2 Accident filled in by the within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD who completed cause of death (Item 23a) (Type, Print) Medical Pruy 31. Date filed (Month, State Registrar

			Please 1		ck Indelible Ink. Ensure A Department of Health and I		•
		-	For Stete Registrer	State of Maryland /	Certificate of Death	vieritai mygier Reg. t	0001 00000
Dh.	oieic	ıg .	1. Decedent's Name (First, Middle, Last	/ / / //		2. Date of Death	3. Time of Death
	/sicia ledic		reggy So	atchell		SEPT (	2004 1831 M
Exa	amin		4a. Facility blamb (If not institution, give SINAL HOSPITAL		4b. City, Town, or Location of Death BALTIMORE C	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Ac. County of Death
Func	eral	_	5. Social Security Number 6. Se		irthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
Direc	tor	g	Usual Residence of Decedent	M 2AF 80	Yrs.	May 6, 19	124 Maryland
If I I I I I I I I I I I I I I I I I I	3		10a. State 10b. County	10c. City, Tox	wn or Location		10d. Inside City Limits
hе Ма	allia	ecto	Maryland N/F	B	altimore	10- /	1 TYes 2 No
with t	100	Funeral Director	10e. Street and Number	wood Picch	10f. Zip Code	109. 0	Citizen of What Country?
death		Inera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race · American Indian, Black, White, etc.
rs afte	rang	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>໘</b> No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Plack
2 hou	200	ted	15. Decedent's Edu (Specify only highest grad	cation 16a	a. Decedent's Usual Occupation	16b.	Kind of Business/Industry
II YIGHTU Z I Z I J-0000 should be filed within 72 hours after death with the Marylar nd Mental Hygiene. marked other then "neturel", or Items 23e or 28e-1 show	N Mer	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired)	Nill g	0/046
filed v Hygie othert	eut,		17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Maid	en Sumame)
should be filed with and Mental Hygiene.	atic ev	To Be	Charles S	atchell	Anni	e Wa	IKer
VICINO 12 sho h and 7 Is ma	reum		19a. Informant's Name/Relationship (7)	rpe, Print) (Son) 19	b. Mailing Address (Street and Number or Ru	ral Route Number, City	or Town, State, Zip Code)
To, IV	other	ij.	20a. Method of Disposition		of Disposition (Name of ery, crematory or other place)	Date 20c.	Location - City or Town, State
Pages nent of I	ury or		1 ☐ Burial 2 X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	3/2004 E	salto Md.
permit. Pages 1 an Department of Heal Importent: If item 2	eny injury or other treumetic event, i'm Mrzigal Esana nat must be notings at 0008.		21. Signature of Funeral Service Cens		22. Name and Address Pacility	Funeral	Home
		-	23a. Pag . Enter the dispase, or comp	ications that caused the death. Do	not enter the mode of dying, such as cardiac	e. Balto. or respiratory arrest,	Md. 21216 Approximate
Pnysic	ian.		shock, or heart fail fre. List only of Immediate Cause (Final disease or condition	ne cause on each line.	AL FAILURE		Interval Between Onset and Death
/Medi Exami	ical		resulting in death)	Due to (or as a consequence			I WEEK
	1101	ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a consequence	e) of):		
wecuted and	transit	amine	cause. Enter Underlying Cause (Disease or injury that initiated events	c			
5 8 G		ш́.	resulting in death) Last	Due to (or as a consequence	of):		
ficate be e	s the b	edlca	•	d			
ecords, F.O. DOX 00/00, law requires that the death certificate be ex as been signed by the attending physician.	l use a	Physician/Medical	230. was decedent pregnant	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal deat	h 3 Ectopic pregnancy		23d. Date of delivery
ne dea	thed fo	ysici	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)		Month Day Year
s that the	e detac	by Ph	Part II. Other significant conditions co			23e. Did tobacci	o use contribute to the cause of death?
law requires that as been signed t	onld b		Coronory orton	diseaso, soiz	uro disorder,	1 🗆 Yes	2 No 3 Probably 4 Unknown
e lawr has be	CA	Completed	dementia, di	verticulosis		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
vicien: The law	or, pag	e Cor	OF Was seen referred to modical		00 Div. (D.	performed?	death? 1 ☐ Yes 2 ☐ No
ysicie ysicie	director, page	o B	25. Was case referred to medical examiner?  1 Tyes 2 No	Hospital: 1X Inpatient 2 ☐ ER/C	Other	th (Check only one) ome 5 - Residence	6 ☐Other (Specify)
JII OI Jing Phys	uneral	on: T	27. Manner of Death  1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b.	Time of 28c. Injury at Injury Work?	28d. Describe how in	
VISION Attending or death. rector: Afte	y the f	ertification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, t	M 1 ☐ Yes 2 ☐ No	28f. Location (Street	and Number or Rural Route Number,
Safter safter al Dire	q ui pe	Certi	4 Homicide	building, etc. (Specify)		City or Town, Sta	ate)
DIVISION OF VICE To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific	completely filled in by the funeral	edical (	29a. Certifier (Check only one) Certifying Phy	sicien: To the best of my knowledginer: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
To the within ?	comple	Med	29b. Signature and title of certifier		29c. License number	29d. E	Date signed (Month, Day, Year)
			1 Kar 1	MD MD	LES-000	SE	PT 6,2004
	2		30. Name and address of person who call the LINE			ITH OF	BALTIMORE
	0		HT ILLEIVE		1	11/1-01	TATELLI I / IU/Line

State Registrar LATHERINE
31. Date filed (Month, Day, Year) SEP 0 9 2004

N McTWTPE, MD

32. Registrar's Signature

04

200		Registrar  Decedent's Name (First, Middle, La	State of Maryland / Dep #23a&27 per me G83	ennicate of Death	2. Date of D		3. Time of Death
hysician /Medical		Christo	pher Michael Sti	cht	Septer		0439 P.
xaminer		a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or Location		4c. County of Deatl	1
		Shady Grove Adver		Rockville	er 24 Hrs. 8. Date of B	Montgomer	y County  pplace (State or Foreign
neral ector		214-32-3263	7. Age (In yrs. last birthday 57 Yrs.	Months Days Hours		Pav. Year)   Col	ington, DC
now	1	Jsual Residence of Decedent  Oa. State 10b. County	10c. City, Town or I	ocation			10d. Inside City Limits
indiffied at		Maryland Montgo	omery Poto	Mac 10f. Zip Code		10g. Citizen of What Co	1 ☐ Yes 2X N
ral Dir		13535 Haywort	h Drive	20854		USA	,
ine ine	1	1. Marital Status  1 X Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Amed Forces? 1 ∑Yes 2 ☐ No	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	Origin? (Specify Yes or Nan, Puerto Rican, etc.)	lo- 14. Race - Ame Black, White	
ý		3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 No Specif	fy:	Specify:	White
t, the wadical Ex.	_	15. Decedent's E (Specify only highest gr.	ade completed) (Giv	edent's Usual Occupation e kind of work done during m DO NOT use retired)	ost of working	16b. Kind of Business/l	ndustry
ent, the M		Elementary/Secondary (0-12)	College (1-4or 5+) 1	Sales		Office S	upplies
reumatic event, II  To Be Co	1	7. Father's Name (First, Middle, Last			her's Name (First, Middl		
other treumatic e	2 _	Roger John S		ling Address (Street and Num		rie Shemas	
Importent: If item 27 any injury or other tre		20a. Method of Disposition  1	Baltimore,	Baltimore, MD  nc. re, MD 21228			
	+	23a Part1. Enter the disease, or com	polications that caused the death. Do not ex	199 Frederick Inter the mode of dying, such a	KOAG BALTIM as cardiac or respiratory	ore, MD 212/ arrest,	Approximate Interval Between
ician		shock, or heart failure. List only Immediate Cause (Final disease or condition	Complications Of	f Chronic Alco	oholism		Onset and Death
dical liner		resulting in death)	Due to (or as a consequence of):				
ial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):				
Dur G	3	resulting in death) Last	Due to (or as a consequence of):				
for use a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
5   ≥		art II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Pai		tobacco use contribute to	the cause of death?
						s an opsy prior to death?	topsy findings available completion of cause of
	-			QC Die	1 X Yes	2 No 1 XYes	2□ No
page 2 should		35. Was case reterred to medical			ice of Death (Check only		ify)
Il director, page 2 should	2	25. Was case reterred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2 XER/Outpati	ent 3 DOA Other: 4	Nursing Home 5 Res		
nneral director, page 2 should on: To Be Completed	2	examiner?	28a. Date of Injury (Month, Day Year)  28b. Time Injury	ent 3 DOA Other: 4 of 28c. Injury at	28d. Describe	how injury occurred	
ineral director, page 2 should	2	examiner?  1 Y Yes 2 No  27. Manner of Death  1 Notural 5 Pending	28a. Date of Injury (Month, Day Year)  28a. Place of Injury 28b. Time Injury	ont 3 DOA Other: 4 of 28c. Injury at Work?  M 1 Yes 2	28d. Describe No 28f. Location		ral Route Number,
ineral director, page 2 should on: To Be Completed		examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigatic investigatic determined  3 Suicide 6 Could not to determined  29a. Certifier 1 Certifying P	28a. Date of Injury  28b. Place of Injury - At home, farm, see 1	of 28c. Injury at Work?  M 1 Yes 2 street, factory, office	28d. Describe 28f. Location City or To	how injury occurred  (Street and Number or Ruown, State)  e cause(s) and manner as	stated.
nis certificate has been sil director, page 2 should		examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigate 3 Suicide 6 Could not to determined  29a. Certifier (Check only 2 Medical Example)	28a. Date of Injury (Month, Day Year)  28b. Time Injury 28b. Place of Injury - At home, farm, s building, etc. (Specify)  hysician: To the best of my knowledge, dec	of 28c. Injury at Work?  M 1 Yes 2 street, factory, office	28d. Describe 28f. Location City or To and place, and due to the eath occurred at the time	how injury occurred  (Street and Number or Ruown, State)  e cause(s) and manner as	stated. to the cause(s)  b. Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Yeer **Physician** EDWARD J. SCHMIDT SEPTEMBER 2004 12:30 P /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner PARKVILLE BALTIMORE MORNINGSIDE HOUSE OF SATYR HILL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** 1⊠M 2□F Months Days Hours Director Yrs. 215-01-6703 94 12/11/1909 MISSISSIPPI Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits Completed by Funeral Director BALTIMORE 1 ☐ Yes 2 X No PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1831 GLEN RIDGE ROAD 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ₺ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6TH GRADE POSTAL CLERK U.S. POSTAL SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 CHARLES SCHMIDT MARY SZYMANSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLEEN KABLIS DAUGHTER 1831 GLEN RIDGE ROAD BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State tXDBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) HOLY ROSARY CEMETERY 9/11/2004 DUNDALK, MARYLAND 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Path 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** 40 coroli disease or condition resulting in death) /Medical Due to (of as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due o (or as a con uence of) Examiner burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed iding physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1□Yes 2☑No Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 Residence 6 Other SISTED LIVING 3 DOA : After this funeral o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 ☑Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D44315 cause of death (Item 23a) (Type, Print) Grippo, MD 30. Name and address of person who completed AVENUE 2801 FOSTER BALTIMORE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar SFP 0 9 2004

DHMH 17 Rev 1/2001

ORIGINAL

		1 - State RegistraMEND ITEM #7		Certific	cate of l	Death	Reg	. No.	4 28600
Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Death		Year 3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give s	SHIFLET		City Town or	r Location of Death	260	4c. County of	004 952 M
⊏xaimn	er	GOOD SAMARITAA			HETIMOR			BALTI	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi	irthday) If U	Inder 1 Year	If Under 24 Hrs.	8. Date of Birth	934	9. Birthplace (State or Foreign
Director		215-28-8500	<sup>1M 2□ F</sup> <del>72</del> <b>70</b>	Yrs. Mon	nths Days	Hours Min.	8. Date of Birth Month, Day, Y	32	Country) <b>V1RGIN1A</b> Mary land
pug &		Usual Residence of Decedent  10a. State 10b. County	10c City Toy	vn or Location					Taga ta sia ga a si si
faryla sho	5								10d. Inside City Limits 1 ☐ Yes 2 🕅 No
h the Maryland r 286-1 show	Director	laryland Anne Ar	undel   Mille	ersvill	f. Zio Code		100	. Citizen of W	
23a or		8388 Oakwood Roa	d	101	2110	18	109	USA	nat Country?
ms 2	Funeral		12. Was Decedent Ever in U.S.	13. Was D		ispanic Origin? (Spe in, Mexican, Puerto	cify Yes or No-	14. Race	- American Indian,
72 hours after death with the Maryland natural, or Items 23a or 28e-f show areal Exeminet must be mulfied at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 □XYes 2 □ No  If Yes, Give Year or Dates: 49-51	1 TY	specify Cuba es 2 🗓 No	sn, Mexican, Puerto l Specify:	Rican, etc.)	Specify:	white, etc.
natural',	Completed	15. Decedent's Educ	cation 16a	. Decedent's	Usual Occupa	ation	16	b. Kind of Bus	siness/Industry
E 2 30	ple	(Specify only highest grade	College (1-4or 5+)	(Give kind o life. DO NO	of work done d OT use retired	during most of workii f)	ng		•
ad wi	Con	6th		welder	/pipef	itter		sh	nip repair
be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	01			18. Mother's Name	(First, Middle, Ma.		,
ould Men varke	၉	Grover		iflett		Ruby			yer
s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other then other traumatic event, the M.		19a. Informant's Name/Relationship ( <i>Ty</i> ) Linda Shiflett da	aughter	Mailing Add. c	tress (Street a 8 Oakw	and Number or Ruma OOd Road	<i>i R</i> oute Number, C Millersvi	ille MD	State, <i>Zip Code)</i> ) 21108
es 1 al of Hea of Hea r othe		20a. Method of Disposition	comata	of Disposition	(Name of or other place	(e)	ate 20	c. Location - C	City or Town, State
Page nent c ant: If ury or		1 ⊠ Burial 2 □ Cremation 3 □ R  1 □ Donation 5 □ Other (Specify)	emoval from State			tery 9/10	/04 G1	len Bur	nie MD
permit. Pages Department of I Important: If ite any injury or of once.		21. Signature V Funeral Service Livense	12 /	22. Nam	e and Addres	ss of Facility C+	_		Home P.A.
90 = 90		· Dund.	33/	3	111 Mo	untain Do	ad Dacade	MD and	
		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death. Do	not enter the	mode of dying	g, such as cardiac o	r respiratory arrest	'	Approximate Interval Between
Physician	i n	Immediate Cause (Final disease or condition	A COLUMN	CARDI		INFARC	TION		Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence	of):					
- Adminier		Sequentially list conditions,	CORONARY	ARTE	ERY	DISEASE			
isi .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):					
ician and	хап	that initiated events resulting in death) Last	Due to (or as a consequence	of):					
ohysician the buria	60			3.7.					
	용		l						
e attending pt id for use as t	hyslclan/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnancy					23d. Date	of delivery
d for	cla	in the past 12 months?	1 Live birth 2 Fetal death	n 3 ⊟Ectop 5 ⊟ Other	ic pregnancy r (specify)			Monti	,
ed by the a	hys	9 Unknown	9□ Unknown						
det	^	Part II. Other significant conditions con	tributing to death but not resulting i	n the underlyi	ng cause give	en in Part I.	23e. Did tobac	co use contrib	oute to the cause of death?
S TI	edt						1 ☐ Yes	2 □ No 3	Probably 4 Unknown
- O 15	ompleted						24a. Was an	24b. We	ere autopsy findings available
certificate has rector, page 2	ШО						autopsy performer	d? de	or to completion of cause of ath?
tifica tor. p	O	25. Was case referred to medical				26. Place of Death	(Check only one)	NO IL	Yes 2 No
	O B	examiner? 1 ☐ Yes 2 No	ospital:	utpatient 3	DOA Othe	AP.	ne 5 Residence	a 6 Other	(Specify)
Jing Phys J. After this funeral di	Į.	27. Manner of Veath	28a. Date of Injury 28b.	Time of Injury	28c. Injury Work	at 2	8d. Describe how i		
C 45 -	atlo	1 Natural 5 Pending 2 Accident investigation	(worth, bay roal)	M		res 2 □No			
ath.	-2	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa	ırm, street, fac	ctory, office	2	8f. Location (Stree City or Town, S	t and Number	or Rural Route Number,
er death. rector: Af	≢						0.9 0. 10	ŕ	
re or Arrendin rs after death. el Director: A led in by the fu	Certification:		1						
ne Hospitel or Attendin n 24 hours after death. te Funerel Director; Au letely filled in by the fu		29a. Certifier (Check only one)  1X Certifying Phys	sician: To the best of my knowledge ner: On the basis of examination ar and manner stated.	e, death occur id/or investiga	rred at the time trion, in my op	e, date and place, a pinion, death occurre	nd due to the caused at the time, date	e(s) and mann and place, an	ner as stated. d due to the cause(s)
Funeral Director:	edical	(Crieck only 2[] Medical Examin	ter: On the basis of examination ar	e, death occur nd/or investiga	rred at the time ation, in my op 29c. License	pinion, death occurre	d at the time, date	and place, an	ner as stated. d due to the cause(s)  (Month, Day, Year)
within 24 hours after death.  To the Funerel Director; A completely filled in by the fu	edical	one)	ter: On the basis of examination ar	e, death occur nd/or investiga	ition, in my op	pinion, death occurre	d at the time, date	and place, an	d due to the cause(s)
within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical	one)	and manner stated	nd/or investiga	ition, in my op	pinion, death occurre	d at the time, date	and place, an	d due to the cause(s)
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	29b. Signature and title of certifier	mpleted cause of death (Item 23a)	nd/or investiga	ition, in my op	pinion, death occurre	d at the time, date	and place, an	d due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Co	pies Are Legible.
State of Maryland / Department of Health and Ment	al Hygiene

		1 - For State Registrar	State of	Maryland / [	Certifica			·	Reg. No. 1	29601	
Physici	an	1. Decedent's Name (First, Middle	e, Last) LANO					2. Date of De Month	ath Day Yea	3. Time of Death 4 11:50 A.M	
/Medic Examir		LEOBARDO SOI  4a. Facility Name (If not institution		ber)	4b. City	, Town, or	Location of De	ath	4c. County of De	111100	
		NORTH ARUNDEL  5. Social Security Number		t Ann de un landhie		GLEN r 1 Year	BURNIE If Under 24 H	rs	ANNE ARU		
Funeral Director		547-64-9313	1. M 2□F	7. Age (In yrs. last bir 59	Yrs. Months		Hours Mi	n. B. Date of Bin (Month, Da JAN I		irthplace (State or Foreign XICO	
and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr	n or Location					10d. Inside City Limits	
Mary B-f sho	tor	MARYLAND ANNI	E ARUNDEL	MIL	LERSVIL	LE				1 ☐ Yes 2 🙀 No	
with the	Director	10e. Street and Number	DI ACE			Code			10g. Citizen of What (	•	
death with the Maryland ms 23a or 28a-f show rmst be notified at	Funerai	525 BELMAR  11. Marital Status		dent Ever in U.S. 7-		1108 Ident of His	spanic Origin?	(Specify Yes or No arto Rican, etc.)	No- 14. Race - American Indian,		
d within 72 hours effer death with the Marylan jiene. I then "natural", or items 23e or 28a-1 show the Medical Eternings must be notified at	by Fur	1 Never Married 2 Marr	ried 1 N Yes 2 If Yes, Give	<sup>2□No</sup> 1968	i		n, Mexican, Pue Specify: MI				
2 hour aturai'		3 ☐ Widowed 4 ☐ Divorced	t's Education		Decedent's Usu	al Occupa	tion		16b. Kind of Busines	Hispanic	
within 72 ane. than "na	Completed	Elementary/Secondary (0-12)	st grade completed)  College (1-		ork done di ise retired)	uring most of w	rorking	CAD DENU	AT		
at the	a	12 17. Father's Name (First, Middle,	Last)	M	18. Mother's N	ame (First, Middle,	CAR RENT				
Q 5 0 0	ToB	JOSEPH SOLANO	)			GUADALUPE UNKNOWN					
s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relations ADRIANA E. SOLA	er, City or Town, State, LE, MD 211								
of Head of Hea		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from S	tate cemeter	Disposition (Na y, crematory or	oth <b>er</b> place	,	EPPrie 7,	20c. Location - City of	or Town, State	
permit. Pages 1 Department of H Important: if Ite any injury or ot	١.	4 □ Donation 5 □ Other (S. 21. Signatur Funeral Service	(pecify)	¢ROWNSV	ILLE MD				CROWNSVILL	E, MD	
Depa Impo any is		A A A C	bay1					JNERAL HO	ME P.A. URNIE, MD	21061	
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that so	used the death. Do not line.	ot enter the mod	de of dying	, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- Aus	te myo	cardy	il 1	n far	etron		Onset and Death	
Examiner		Sequentially list conditions	b Ga	rasa consequence o	iestina	l I	Sleed.	ne.			
pei jist	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequence o	of):			8			
cate be executed physician and the burial-transiti	Examin	that initiated events resulting in death) Last	c. Due to (o	r as a consequence of	H):						
cate be physicia the bu	dicai		d								
nding puse as	a)	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy							
	ia	in the past 12 months?	1 Live bir						23d Date of d	elivery	
e death he atte	1   Yes 2   No 9   Unknown 9   Unknown								23d. Date of d Month	elivery Day Year	
thet the death certifined by the attending to detached for use as	/ Physician/M	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnar 9□Unknow		3 Ectopic p 5 Other (sp	pecify)	n in Part I.	23e. Did to		Day Year	
quires thet the deatl en signed by the atte	by	1 ☐ Yes 2 ☐ No	4□Pregnar 9□Unknow	nt at time of death vn	5 Other (sp	pecify)	n in Part I.	23e. Did to	Month  Obacco use contribute	Day Year	
law requires as been sign 2 should be	by	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnar 9□Unknow	nt at time of death vn	5 Other (sp	pecify)	n in Part I.	1 □ Y 24a. Was autop	Month  bbacco use contribute  Yes 2 No 3 ☐ F  an 24b. Were a prior te	Day Year  to the cause of death?  Probably 4 Unknown  autopsy findings available occupietion of cause of	
law requires as been sign 2 should be	Completed by	1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition	4⊟Pregnai 9⊟Unknow ons contributing to dea	nt at time of death vn	5 Other (sp	cause giver		24a. Was autop perfor	Month  bbacco use contribute  fes 2 MNo 3 □ F  an 24b. Were a prior to death? 2 No 1 □ Ye	Day Year  to the cause of death?  Probably 4 Unknown  autopsy findings available occupietion of cause of	
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law requires as been sign 2 should be	To Be Completed by	25. Was case relerred to medical examiner?  1   Yes   2   No   No   No   No   No   No   No	4 □ Pregnai g□ Unknow ons contributing to dea Morel    Hospital: 1 Ing    28a. Cate of (Month,	nt at time of death  on  th but not resulting in  this stress  patient 2 EF/Out  Injury 28b. T.	5 Other (sp the underlying of	cause giver	26. Place of Do  4 □ Nursing	24a. Was autop perforing 1 Tys eath (Check only on Home 5 Resident)	Month  bbacco use contribute  Yes 2 No 3 F  an 24b. Were a sy prior to death? 2 No 1 Ye  ne)	Day Year  to the cause of death?  Probably 4 Unknown  autopsy findings available ocmpletion of cause of less 2 No	
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sician: The law requires certificate has been sign rector, page 2 should be	To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendin investig  3 Suicide 6 Could referred to medical examiner?  29a. Certifier Check only 2 Medical I	Hospital:    Hospital:   Image	nt at time of death vn  th but not resulting in the but not resulting i	patient 3 Domine of jury M and street, lactory death occurred for investigation	cause given  OA Other  Work's  1 Your office	26. Place of Do	24a. Was autop performed at the time, of	Month  bbacco use contribute  fes 22 No 3   F  an	Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available completion of cause of as 2 No  ecify)  Bural Route Number, as stated.	
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				State of Maryland / Dep				_	
			1 = For State Registrar	•	rtificate of			No? DAL	28602
		=	Decedent's Name (First, Middle, Last,				2. Date of Death		3. Time of Death
	Physici		George	Thomas, St	rovel		Month 0 9	O 7 2004	3:45 PM
7-	/Medic Examir		4a. Fecility Name (If not institution, give	street and number)		or Location of Death		4c. County of Death	
			Kernan Ho	spital	Bo	ltimor	e	Balti	more
	Funeral Director		314-18-0261	7. Age (In yrs. last birthday,  M 2 F Yrs.  Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, Y	ear) 9. Birthr Cour CAL3 MAR	place (State or Foreign
	and and		Usuel Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		1		I Od. Inside City Limits
	Many fish	jo	MARYLAND BALTIM	-ox Ack	110				1 ☐ Yes 2 No
	r 288	rec	10e. Street and Number	NICE I FISTON	10f. Zip Code		10g	. Citizen of What Cour	ntry?
	th with	al D	2401206EW00	O AVE	A12	434		U.S.A.	
	dea ams	ner				dispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	cen Indian,
36	or It	J.	Never Married 2 Married	1 ☐ Yes ② No If Yes, Give	1 ☐ Yes 2 No	Specify:	,	Specify:	Stc.
21215-0036	72 hours after death with the Maryland natural; or Rems 23e or 28e-f show Jical Examiner met be notified at	Completed by Funeral Director	3 Widowed 4 Divorced	Year or Dates:	death Heyel Occur			(N)	2115
15-	n 72	jete	15. Decedent's Edu (Specify only highest grad	e completed) (Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ing 16	b. Kind of Business/In	dustry
212	within liene.	шo	Elementary/Secondary (0-12)	College (1-4or 5+)	ISABLE	$\wedge$			
	Hygie other	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
lar	Mental Arked o	To B	HARRY M	STROVEL		MARY	SKLYC	1 BAUS.	R
Maryland	2 should be filed within and Mental Hygiene. Ie marked other then eumatic event, the Mental the Men		19a. Informant's Name/Relationship (Ty	pe, Print) 19b. Mail	ing Address (Street	and Number or Run	al Route Number, C	city or Town, State, Zip	(Code) 2,1234
100	1 and 2 Health Iem 27		LIVOIZ DAZL	12401	EOU WO	DOO AVE	HARKY	MAN SHI	ORPAK
Baltimore,	ot of Line		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20b. Place of Disp cemetery, cre	matory or other place	25/21/25		c. Location - City or To	own, State
E i	permit. Pag Department Importent: I eny injury o		*4 Donation 5 ☐ Other (Specify)	A Lion	RPA	20	04 F	LIH TEST	MARSAM
3al	permit. Departr Importa eny inje		21. Signature - Funeral Service Licens	2	2. Name and Addre	ASS OF Facility	JEMORIE	۵	31234
	40204		See Best Standard	cations that caused the death. Do not en	800 HA		GEO PARY	Critis LIV	COLALD
			shock, or heart failure. List only of	je cause on each line.	Í				Approximate Interval Between Onset and Death
	Physician /Medical		Immediete Cause (Final disease or condition resulting in death)		ies wit	h comp	lieation	```	1 week
	Examiner			Due to (or as a consequence of):					
	- <u>*</u>	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of).			Λ IA()	1	
	sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events			1 + HR	llann.	NER	
ó	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	EX	resulting in death) Last	Due to (or as a consequence of):	7,520	IFICATION APPRO			
3760,	ate be ex nysicien he burial	cal		1.	CERT				( <u></u>
89	leath certificate b attending physic I for use as the b	Physician/Medi	IF FEMALE:					TROUGHAR SE	
Вох	ath ce ttendi	lan/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3[	□Ectopic pregnancy	y		23d. Date of delive Month	ory Day Year
O.	the a	sic	1 Yes 2 No	4☐Pregnant at time of death 5[ 9☐ Unknown	Other (specify)			Month	Day 16a:
P.0.	uires that the de signed by the a d be detached f	Ph		ntributing to death but not resulting in the i	Inderwing cause an	on in Part I	23e Did tohad	co use contribute to the	ne cause of death?
ds,	signe signe d be	d by	Renal F	Failure	andonying cause giv	TOTAL STATE OF THE	1 ☐ Yes	2 ☐ No 3 ☐ Prob	
Ö	w requir been si should	ete	Traumatic	Bonis Laive	<b>N</b>		24a. Was an		
of Vital Records,	has ye 2	Completed	1	111/6/11/11/11/11	1.		autopsy	d? prior to coi	psy findings available mpletion of cause of
a	iician: The lav certificate has rector, page 2	e Co	25. Was case referred to medical	eticle Colli	SION		1 Yes 2 €	No 1 ☐ Yes	2 1 No
Ξ	Physician: r this certificaral director.	To B	examper?	Hospital: 1 Inpatient 2 ER/Outpatie	ot 3 DOA Oth	AP.	(Check only one)	e 6 Other (Specifi	
0	g Phys er this eral dii		27. Manner of Death	28a. Date of Injury 28b. Time of			28d. Describe how		,
ion	ath. r: After e funera	atio	1 ☐ Natural 5 ☐ Pending · investigation	(Month, Day Year) Injury 07,15,2004 08:20	Am 1 □	Yes 2 No	subject "	was Pedest	rian struck
Division	r Atte	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura	
	tel o rs aft el Di	Certification:		rosdusy				Hartord &	1. Baltimore
	Hospi 4 hou uner	edical	(Check only 2 Medical Exami-	sician: To the best of my knowledge, deal ner: On the basis of examination and/or in	th occurred at the tin	me, date and place,	and due to the caus	se(s) and manner as st	ated.
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medi	01107	and manner stated.	29c. Licens				
	Twit of the second	-	29b. Signature and title of certifier	· m D		004463	_	Date signed (Month,	
	10		118			7 7 63		07,01	,2004
	6		1 1 1 1	son 2200 Ker,	Dan De	rive, B	2/+1m.	re, md	•
	Sta	ite	31. Date filed (Month, Day, Year)			, ,		1	
	Registi		SEP 0 9 20	104 Aloeur St A	parte				

Sterling, Themas 1:40 A.M.
Baltimore, Maryland 21215-0036

			For	<b>Type or Prin</b> State of Ma		/ Depa	artment of I	Health and I	•		ble.
			1 - State Registrar			Cei	tificate of	Death		Reg. No.	11. 20002
	Physici		Decedent's Name (First, Middle, Last	) /.					2. Date of D	eath Day	Year 3. Time of Death
j.	/Medi		Thomas St	2/1/114	SR				Septem	Mr3.2	1004 1:4014
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of Death	1	4c. County	of Death
			Stella Maris at	Mercy Hos	pital		Bal	timore   Trunder 24 Hrs.			N/A
	Funeral		5. Social Security Number 6. Se	x 7.Age MIM 2□F	(In yrs. last	t birthday) Yrs.	Months Days		8. Date of Bi (Month, D	ay, Year)	<ol> <li>Birthplace (State or Forei Country)</li> </ol>
	Director		216-70-2772 Usual Residence of Decedent		46	113.			March	20,1958	Maryland
	land ow		10a. State 10b. County		10c. City, T	own or Lo	cation				10d. Inside City Limit
	Man Firsh	ţ	Maryland Anne Aru	ndel	Ba1t	imor	<b>e</b>				1 □ Yes 2 🗷 N
	r 28g	rec	10e. Street and Number			2201	10f. Zip Code			10g. Citizen of W	Vhat Country?
	within 72 hours after death with the Maryland ene. than "naturat", or items 23a or 28a-1 show he Medical Examinat the incilling at	by Funeral Director	7797 Cox Point Cou	rt			21	226		U.S	. Δ
	dea	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S.	13.		Hispanic Origin? (S can, Mexican, Puert	pecify Yes or N		- American Indian,
9	or Ite	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 M N If Yes, Give	lo		T ☐ Yes 2 🛣 No		o riidani, dic.)	Specify	k, White, etc.
8	urat',	d b	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:							White
7	"nat	ete	15. Decedent's Edu (Specify only highest grad	rcation le completed)	1	(Give	lent's Usual Occu kind of work done DO NOT use retire	during most of wor	king	16b. Kind of Bu	siness/Industry
Maryland 21215-0036	withir ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5- N/A	+)			,		m .	T 1 55
ş	fited Hygid ther ant.	ပို	17. Father's Name (First, Middle, Last)	N/A		ır	uck Driv	T	ne (First, Middle	leamst a, Maiden Sumami	ers Local 557
an	ld be ental ked c	To Be	Darrell	Τ.,	C+ a	rlin:	_				
<u></u>	shound Mark	-	19a. Informant's Name/Relationship (7)					Ruth t and Number or Ru	rai Route Numb	er, City or Town.	Blahut State, Zip Code)
Š	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If itam 27 is marked other than "naturat", or items 23a or 28a-f show or other treumatic avant. It a Medical Erabilitating the inclination		Marianne Campbell	(Sistor)	1	175	Dala Da	ad Pasade	re Mer	wlar 1 21	122
ē,	s 1 a f Hee itam otha		20a. Method of Disposition	` ,	20b. Plac	e of Dispo	sition (Name of natory or other pla	au rasaue	Date Date		City or Town, State
Ë	Pages nent of I int: If it		1 ■ Burial 2 □ Cremation 3 □ F  1 ■ Donation 5 □ Other (Specify)		1		en Mem.		/04	Clon Ru	rnie. Marylan
Baltimore,	그 문문 중 .		21. Signature of Funeral Service Licens		1 0101	22	. Name and Addre	ess of Facility			
m	Depa Impo any ii		John F. 6	Mir		Me	Cully-P	olyniak F	uneral	Home, P.	A. MD 21225
			23a. Part. Enter the disease, or comp shock, or heart failure. List only o	lications that caused	the death. I	Do not ent	er the mode of dyi	ing, such as cardiac	or respiratory	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			i.	101	curio			Onset and Death
	/Medical		resulting in death)	a Due to (or as a	consequen	ice of):	3	200,00			
1	Examiner	,	Sequentially list conditions.	b							
	D is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequen	ce of):					
	and I-tran	хаш	that initiated events resulting in death) Last	c.  Due to (or as a	consequen	ce of).					
60,	be executed ician and burial-transit			540 10 (01 43 6	z consoquon	00 01).					
687	phys the	g		d							
×	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If yes, outcome of	of pregnancy	,				22d Date	of delivery
Вох	atter I for L	clar	23b. Was decedent pregnant in the past 12 months? 1 \(\sum \) Yes 2 \(\overline{D}\) No	1 ☐Live birth 2 4 ☐ Pregnant at t	2 🗌 Fetal de	ath 3	Ectopic pregnanc Other (specify) _	;y		Mon	
P.O.	that the ded by the detached	lys	9 ☐ Unknown	9□ Unknown			., ,, =				
	uires that signed t d be det	by P	Part II. Other significant conditions co	ntributing to death bu	it not resultin	ng in the ur	nderlying cause giv	ven in Part I.	23e. Did	tobacco use contri	ibute to the cause of death?
r Sp	quire; n sig uld bu	d b							12	Yes 2□No	3 ☐ Probably 4 ☐Unknow
00	w requir s been si should	Completed							24a. Was	an 24b. W	Vere autopsy findings availab
Be	The lav	mo								psy promed? de	rior to completion of cause of eath?
of Vital Records,		a)	25. Was case referred to medical					26. Place of Dea	1 Yes		Yes 2 No
<u> </u>	Physician: this certificaral director,	To B	examiner?	Hospital: 1 ☐ Inpatier	nt 2 ER	/Outpatien	3 DOA Ott	han	ome 5 Res	-	r (Specify) hospie
0	ding Ph		27. Manner of Death	28a. Date of Injun (Month, Day		b. Time of	28c. Inju. Wo			how injury occurre	
Ö	Attending r death. sctor: After by the fune	atlo	Natural 5 Pending 2 Accident investigation	(Moral, Day	, 54.7	mjury		Yes 2 No			
Division	er de racto by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home	, farm, stre	eet, factory, office		28f. Location (	Street and Numbe wn, State)	er or Rural Route Number,
	Hospital or Attenc 4 hours after death Funaral Diractor: tely filled in by the	Cer		,					-	, 0.2.0)	
	a Hospita 24 hours Funaral etely filled	cal	29a. Certifier Certifying Phy (Check only 2 Medical Exami	sician: To the best o	f my knowle- examination	dge, death	occurred at the ti	me, date and place	and due to the	cause(s) and man	nner as stated. nd due to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Diractor: After this certific completely filled in by the funeral director.	Medical	one)	and manner stat	ted.				. Je et ille tille,		
	To Tool	2	29b. Signature and title of certifier	$\wedge$			29c. Licens	D 40854		i	(Month, Day, Year)
•			1 DV 1/2	1-				70877 7		413	12004
	10		30. Name and address of person who co	ompleted cause of de			ol S.	1. Paul	PL (	5 n l-1 mer	21202
	Sta	ato.	31. Date filed (Month, Day, Year)		r's Sign		18.1	*****		71	- 18
	318	T.E	5 M A D 2000	27.0 .0	2/A	4.0	Section 1				

			1 - For State Registrar	State of Maryl		artment of H		ntal Hygier	2001	28604
	Physic		1. Decedent's Name (First, Middle, Last)				2	. Date of Death Month	Day Year	3. Time of Death
	/Medi		Amelia T.	Sorrentino			S	eptember	,	4:40 PMM
}	Examir	ner	4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		tc. County of Death	
			Carroll Hospital  5. Social Security Number 6. Sex		In a himboria	Westmins If Under 1 Year		2 (2)	Carrol1	
н	Funeral Director			M 20 F 88	yrs. last birthday) Yrs.	Months Days	Hours Min.	. Date of Birth (Month, Day, Yea		ace (State or Foreign ry)
			Usual Residence of Decedent	Α   66			J.	anuary 10	) 1916 Ne	w York
	nylan how		10a. State 10b. County	10c	. City, Town or Lo	cation			10	d. Inside City Limits
	e Ma	cto	N.J. Essex		Livingst	on				1 ☐ Yes 2 ☐ No
	dith th	Dire	10e. Street and Number			10f. Zip Code		10g. (	Citizen of What Count	ry?
	s 23e	Funeral Director	156 E. Cedar Stre			07039			nited Stat	
	ter de Item	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever   Armed Forces? 1 ☐ Yes 【 No	in U.S. 13.	Nas Decedent of His f Yes, specify Cubar	spanic Origin? (Specil n, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - America Black, White, e	
336	urs af	by F	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2☐No	Specify:		Specify: Whi	te
21215-0036	72 hours after death with the Maryland natural; or Items 23e or 28a-f show died Examinational be nutilized at	ted	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occupa	ition	16b.	Kind of Business/Indu	ustry
218	within 7 ene. than "r	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done d DO NOT use retired)	uring most of working			
21	filed wi Hygien thar th	Completed	12	0	Hc	me Maker	_		Homemaker	
pu	be fill tal H id oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (F	First, Middle, Maid	en Sumame)	
<u>\sqr</u>	2 should be filed withir and Mental Hygiene. Is marked other than aumetic avant, II e M.	은	Alfonso Desider				Gaetana	Frac		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. item 27 is marked other than "netural", or items 23e or 28e-f show other traumetic event, Ir.e. Modical Exactions I.e. multiple of the traumetic event, Ir.e. Modical Exactions I.e. multiple of the traumetic event, Ir.e. Modical Exactions II.e. multiple of the traumetic event, Ir.e. Modical Exactions III.	1 8	19a. Informant's Name/Relationship (Ty)						or Town, State, Zip (	Code)
	s 1 and si Health itam 27 other tra	1	Anne S. Johnston  20a. Method of Disposition		r 256 N	ladison Av	venue, Pive	redge, N	Location - City or Tow	
5	eg ÷ = 5		1X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, crer	natory`or other place	9)			
altimore,	- E # = -	. 4	<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>			leaven Cem			t Hanover, Funeral Di	N. J.
Ba	Depar Impo any ir		I Grand Ra		333 8	728 Liber	tv Road. F	ig byers Randallst	own, MD. 2	rectors 01133_4784
			23a. Part   Enter the disease or compli	cations that caused the o						Approximate
I	Pnysician /Medical	-	show, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con	sequence of):					Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequence of):					
Ć,	be executed sician and burial-transit	Examine	that initiated events cresulting in death) Last	Due to (or as a con	sequence of):					
68760	ficate be physicial s the bur	edlcal								
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month D	/ Day Year
Δ.	quires that n signed b uld be deta	by	Part II. Other significant conditions con	tributing to death but not	resulting in the ur	nderlying cause giver	n in Part I.	23e. Did tobacco	use contribute to the	cause of death?
00	aw requir is been s 2 should	Completed	SEVERE GASTRIT	IS AND	LARI	GE ITIAT	AL HORNIA	24a. Was an	24b. Were autops	sy findings available
R	The la ate ha page 2	шо				11000	1000	autopsy performed?	prior to comp death?	pletion of cause of
ita		0	25. Was case referred to medical				26. Place of Death (C	1 Yes 2 K	0 1 ☐ Yes 2	□ No
f V	nysic lis ce direc	To B	examiner?	ospital: 1 Thpatient	2 ER/Outpatien	Othor			6 ☐Other (Specify)	7.17.7
0 _	ding Ph h. After th funeral		27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injury Work		. Describe how inj		
Sio	eatheath	catle	2 ☐ Accident investigation				es 2 🗆 No			
Division of Vital Records,	5 # in a	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, stre ecify)	eet, factory, office	28f.	Location (Street a City or Town, Sta	ind Number or Rural F te)	Route Number,
	To the Hospital or within 24 hours after To the Funeral Dit completely filled in	edical	29a. Certifier 1 Sertifying Phys 2 Medical Examinate	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	estigation, in my opi	nion, death occurred a	due to the cause( at the time, date an	s) and manner as stat nd place, and due to th	ed. ne cause(s)
	To To Com	Σ	29b. Signature and title of certifier		M·D.	29c. License			ate signed (Month, Da	ay, Year)
•	17				77. 9.	7)00	154580	4	15/4	
	10			1.0. 417-	E B	Print) ALTMO	RE ST =	# D, T	MEYTOWN	MD2178-
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pagistrar's Si	gnature	and a				

State of Maryland / Department of Health and Mental Hygiene 1- State Amend item 7,8,18 per infg835 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Cynthia Marie Strong Sept 2004 3:00 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yell 1956 Sent 28, 195 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1□M 2√√ <del>46</del> 47 069 48 2390 Director 57 New York Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14349 Rosetree Court Items 23a 20910 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. med Forces:

Yes 2 No 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ If Yes, Give Z 1□Yes 2□X0 Specify. Specify: Black Completed by 3 ☐ Widowed XX Divorced "neture!" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Hunton & Williams Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond Strong Naomi Kir Kitcart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 st of Health ar Karen Jenkins (POA) 10306 Twin Knollway, Upper Marlboro, Maryland 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages
Department of I
Importent: If it
any injury or o ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Sept 8,2004 Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Linerse MO0 362 Alexandria Ferry Rd, Clinton, Maryland 20735 23a. Parf1. Enter the disease, or camplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Minutes Immediate Cause (Final disease or condition resulting in death) Acute Aspiration **Physician** /Medical Due to (or as a consequence of) **Examiner** 2 weeks Gastrointestinal Hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 'n End Stage Renal Disease; Sepsis; Protien S deficiency 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should. Be Completed 24a. Was an autopsy performed? with vena caval thrombosis; Malnutritian 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2₹₹No or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∏thpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ XX Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1X Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel I Var Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of centifie 29c. License number 29d. Date signed (Month, Day, Year) Sept. 9, 2004 D 47188 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Perlmutter, M.D. 6240 Montrose Road Rockville, MD 20852 Jeffrey A. 32 Registrar's Signature 31. Date filed (Month, Day, Year) SEP 0 9 2004 Registrar

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 11:10AM tember4 2004 Lorraine Eleanor Schylaske /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOSPITO KOSERO L If Under 1 Year If Under 24 Hrs. Canole Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 ☐ M 2 🂢 F Yrs. **Director** 201-18-5732 <u>11</u>/10/1926 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2X No Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2216 Vailthorne Road 21220 U. S. Α. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2√☐ No Specify: ģ 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M. Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Clerk Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Roy Frantz Helen Rayder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1557 Harford Square Drive Edgewood, MD 21040 <u>Joseph Schylaske</u> (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 9/9 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenwood Cemetery 2004 Tower City, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 23a. Part1. Enter the disease, ir confirm tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Essex, Maryland 21221 Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician seudomemblanous Wee /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Energy of the Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physicien and hed for use as the burial-transit certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 mmths? Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 ☐ No 24a. Was an autopsy performed? 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☑ Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29b. Sign sture and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

SEP 0 9 2004

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32. Registrar's Signature sports

son who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene State Certificate of Death
Registrar MFND TTFM #5 PER FII G836 10/14/04 JH

acadent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** September 6, 2004 12:15 A M Dorothy Α. Sacks /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Exerciper must be notified at 1 ☐ Yes 2 X No Directo Maryland Baltimore Parkville 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21234 U.S.A. 9005 Briar Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Assessment Clerk 12 Baltimore County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event 2008. Be ٩ Alexander Zezulinski/Silenski Frances Wieciech 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9005 Briar Road Parkville, Maryland 21234 Norman G. Sacks Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Holy Rosary Cemetery 9-11-2004 Baltimore Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21, Signature of Foneral Service Licensee 1050 York Road Hagan Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition OVARIAN Cancer months **Physician** /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2/1 No 9 Unknown 3 ☐Ectopic pregnancy Year jo Month Day 5 Other (specify) been signed by the sahould be detached 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) within 24 hours effer death.

To the Funerel Director: After thi
completely filled in by the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; Injury 5 Pending 1 Matural 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53303 Seprember 6 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

ATLOW (MM(L) MM) (660) N - Charles Towsin ATRON Chonles 31. Date filed (Month, Day, Year) State SEP 0 9 2004 Registrar

Baltimore, Maryland 21215-0036

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Division

			1 - For State Registrar	State of Maryland		rtment of H		lental Hy	giene Reg. No?		2860	R
	Physici	an	1. Decedent's Name (First, Middle, Last)	CHALICIZ				2. Date of De Month	eath Day	Year	3. Time of De	ath
	/Medic	al	HARRY LEROY  4a. Facility Name (If not institution, give str	SHAUCK		4h City Town or	Location of Death	SEPTEM		2004 hty of Death	1:13P	M
	Examin	ier	STELLA MARIS HOSPIC			TOW				ALTIM		
İ	Funeral Director		213 07 0173	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 11-2-19	rth ay, Year) 915	9. Birth Con MA	nplace (State or F untry) RYLAND	oreign
	yland sow		Usual Residence of Decedent  10a. State 10b. County		Town or Lo	cation					10d. Inside City I	imits
	e Mar 3e-1 sh	ctor	MD BALTI	4ORE			ROSEDALF				1 Tes 2	XNo
J.	with th	Funeral Director	10e. Street and Number 8107 CALLO LANE			10f. Zip Code	01007		10g. Citizen o		•	
p.m	death ms 23	erai		. Was Decedent Ever in U.S	i. 13. V		21237 ispanic Origin? (Spin, Mexican, Puerto	ecify Yes or No	o- 14. R	U.S	A.	
1:13	s 1 and 2 should be tiled within 72 hours after death with the Maryland if Health and Mental Hygiene. If the atth and Mental Hygiene if the marked other than "natural", or Items 23a or 28e-f show other traumatic avent, the Medical Examiner must be multiled at		1 ☐ Never Married 2 ☐ Married  ③CXWidowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 █️No If Yes, Give Year or Dates:		Yes, specify Cuba ☐ Yes 2 X No	n, Mexican, Puerto Specify:	Rican, etc.)	Spec	lack, White	o, etc. WHITE	
. 0	72 hc natur	eted	15. Decedent's Educa (Specify only highest grade of	tion completed)	(Give	ent's Usual Occupa	during most of work.	ing	16b. Kind of	Business/I	ndustry	
2004 d 2121	e filed within al Hygiene.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		O NOT use retired  KEEPING	" SUPERVIS	OR.	GLEN :	Ι ΜΔΡ	TTN	
20	e filed Il Hygi other	Be Co	17. Father's Name (First, Middle, Last)			, respirato	18. Mother's Name				TIIV	
02, rvlar	should be nd Mental marked o	To B	HARRY SHAUCE	ζ			IRENE		COLEMAN	<u> </u>		
ER.	and 2 sho saith and n 27 is m		19a. Informant's Name/Relationship (Type GLORIA BANZ/ DAUGH:		19b. Mailin 8107	g Address (Street a	and Number or Rura ANE ROSE	DALE, N	er, City or Tow. 1D 212.		ip Code)	
SEPTEMBER	ges 1 t of He if Itan or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer		nce of Dispos metery, cren	sition (Name of natory or other place	(e)	Date	20c. Location	ı - City or T	own, State	
EPT Him	permit. Pages Department of I Important: If It any injury or o		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licenspe	HOL		RY CEMET		2004	BALTI	MORE,	MARYLAN	D
S	Depa Impo any is		21. Signature of Allelan Solvice Electrise	Xta			ss of Facility CVA CO AVENUE		EDALE FO EDALE, 1		L НОМЕ 1237	
	Physician	28	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	tions that caused the death. cause on each line. End Sta	Do not ente	er the mode of dying				<u> </u>	Approximate Interval Betwee Onset and Dea	en ith
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):							
1	LAdillilei	70	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
8760	ate be executed hysician and the burial-transit	cal	resulting in death) Last	Due to (or as a conseque	ence of):							
99 ×		Med	IF FEMALE:	W					F			
O. Bo	the death certifica y the attending ph iched for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	if yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)				ate of deliv Month	rery Day Yea	r
rds. P	w requires that the de been signed by the a should be detached f		Part II. Other significant conditions contri	buting to death but not result	ting in the un	derlying cause give	en in Part I.		obacco use co Yes 2 ☐ No		the cause of deat	
JCK, HARRY Division of Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certifica roleath.  sctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the standard of the set of the funeral director, page 2 should be detached for use as the standard of the set	Completed						24a. Was autop perio 1 🗆 Yes		prior to co death?	opsy findings ava ompletion of caus	ilable e of
ĭ Vits	certifi	Be	25. Was case referred to medical examiner?	spital:		Othe	26. Place of Death					
HARRY on of N	Phys er this	n: To	27. Manner of Death	1   Inpatient 2   E	R/Outpatient 28b. Time of	3 DOA 28c. Injury Work	at Nursing Hor		dence 6 X OI		My Hospi	ce
HA ion	uttending death. ctor: Afte y the fun	atio	2 Accident investigation	(Month, Day Year)	Injury		(? Yes 2 □No					
SHAUCK, Divis	Diric fe	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Num vn, State)	iber or Rur	al Route Number	
7HS	ha Hospitel in 24 hours a ha Funeral I pletely filled	Medical	29a. Certifier (Check only one)	ian: To the best of my know f: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the timestigation, in my op	ee, date and place, a pinion, death occurr	and due to the ed at the time,	cause(s) and m date and place	nanner as s , and due t	stated. to the cause(s)	
	To t To t com	Σ	29b. Signature and title of certifier			29c. License	3725		29d. Date sign Septem		Day, Year) 2, 2004	
	10		30. Name and address of person who com Tariq Mahmood, M.			<sub>Print)</sub> Valley F	Rd. Timor	nium, M	D. 21	.093		
	Sta		31. Date filed (Month, Day, Year)	32. Regitrar's Signatu	ire &	land.						
	Registr		SED 0 3 50	04 Kleen	N. 19	Service .						

State of Maryland / Department of Health and Mental Hygiene

					(	Certifica	te of I	Death		Reg. No.)	11. 20000
	<b>D</b>		1. Decedent's Name (First, Middle, Las						2. Dete of De Month		Year (3. Time of Death)
	Physici /Medic		ABraham	STEIN	J				09	06 2	2004 0720A
	Examin		4a Fecitity Neme (If not institution, give	street end number)			4	b. City, Town, or	Location of Deet	h 4c. County o	of Death
			Jenesis Br	ight wood		Nter	- 1	-uther	ville	15a	1+1more
	Funeral		5. Social Security Number 6. Se	DUNGOL	lest birth	Months	er 1 Year Deys	If Under 24 Hrs Hours Min.		v. Yeer)	Birthplece (State or Foreign Country)
	Director		Usuel Residence of Decedent	94					104-0	2-1910	MD
	pue #	ŀ	10a. Stete 10b. County	10c. Ci	ty, Town	or Location					10d. Inside City Limits
	Mary	ট	MD BALTI	IMORE					LUTHER	VILLE	1 ☐ Yes 2 ☐ No
	with the Marylen a or 28a-f show be notified at	Director	10e. Street end Number			10f. Z	ip Code			10g. Citizen of W	/hat Country?
	h with		515 BRIGHTFIELD	ROAD				21093			USA
	Herne 2	Funeral	11. Merital Status	12. Was Decedent Ever in U Armed Forces?	J,S.	13. Was Dec	edent of H	ispenic Origin? (S In, Mexican, Puer	specify Yes or No	- 14. Race	e - Americen Indian, k, White, etc.
21215-0020	g 9 E	P	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🂢 Divorced	1 Yes 2 No If Yes, Give Yeer or Detes:		1 ☐ Yes		Specify:	,	Specify:	
5-0	"natural", edical Ex	ete Det	15. Decedent's Ed (Specify only highest grad	ucation de completed)	6	Decedent's Us Give kind of w	vork done	during most of wo	rking	16b. Kind of Bus	siness/Industry
121	within ene. than "	Completed	Elementery/Secondary (0-12)	College (1-4or 5+)	1	life. DO NOT	use retired	)		MENIC (	LOTUINO
	70 70 1		17.5-11-11-11-11-15-11-11-11-11-11-11-11-11		PRU	PRIETO	K	19. Mothar's Na	no (First Middle	MEN'S (;	
anc	ad ta b	Be	17. Father's Neme (First, Middle, Last) LOUIS		ст	EIN			ne (riist, middle	, Maiden Sumame	
Maryland	should ind Men in marke umarke	٤	19a. Informant's Name/Reletionship (7	Simo Print)			ec (Street	ANNA and Number or Bi	urel Route Numb	er, City or Town, S	I SAACSON State Zin Code)
Ma	O1 00 00 00		JEAN LABOVITZ /								E. MD 21208
a,	s 1 and 2 f Health frem 27 other tra	-	20a. Method of Disposition	20b. I	Place of D	Disposition (N	eme of		Date		City or Town, State
Baltimore,	permit. Pages Department of i mportant; if Its any Injury or o		1	BET			NSHE	KURLAND		BALTIM	
Bal	Depar Impor any in		21. Signature of Funeral Service Licen	attle							OS., INC. LE, MD 21208
	NY OUT		23e. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the dea	th. Do no	ot enter the me	ode of dyin	g, such es cerdia	c or respiratory a	rrest,	Approximate tnterval Between
*	Physician										Onset and Death
74	/Medical Examiner		Immediate Cause (Final disease or condition	C. 5	SPT	7 81	nd.	Svage			Months 5
	C.kallillel	_	resulting in death)	Due to (	or es a co	onsequence o	f):	0			1
1	sit ed	- Ine		a. C S Due to (c	ler	stil	Ca	ndiov	oscul	an	montes
1	death certificate be executed the ettending physician end ed for usa as the burial-trensit	Examiner	Sequentially list conditions, if env. leading to immediate	Due to (	or es e co	nsequence o	f):		Disco	me	
68760,	be eg	ai	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	c							
387	phys phys s the	edicai	that initieted events resulting in death) Last	Due to (d	or as e co	nsequence of	):				
	certific Iding p	2		d							
Box	leath ce ettendia d for usa	ciai	Part II. Other significant conditions co	natributing to dooth but not re-	ulting in t	the underlying	cause div	en in Part I	23h Did	toharco use con	tribute to the cause of death?
o.	t the de by the e	Physician/	Part II. Other significant conditions co	intributing to deeth but not res	sulling in	ine underlying	r cause giv	our in Fait i.			3 Probably 4 Unknown
Φ,	as that igned t be dat	by P									
of Vital Records,	The law requiras that the ste has been signed by th paga 2 should be datache	Completed t								en eutopsy ormed?	24b. Were autopsy findings available prior to completion of cause
<b>3ec</b>	has has bas 2 s	ם							100	n cours	of death?
a										Y95 2LING	1 ☐ Yes 2 ☐ No
<u>Ş</u>	Physician: Th this cartificete rel director, pa	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ Nto	Hospital: 1 ☐ Inpatient 2 ☐	1 ED/Oute	patient 3 1	Oth	or.	ath (Check only	one)idence 6 □Othe	or (Crocife)
	Phys r this rel dii	5 T	1 ☐ Yes 2 ☐ ₩6	28a. Dete of Injury	28b. Tir	me of	28c. Injur Wor			how injury occurre	
O	ding F th. After funer	후	1-⊟Naturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Dey Year)	lnj	jury M		k? Yes 2 □ No			
Division	I or Attanding after death. Director: After d in by the fune	Fica	3 ☐ Suicide 6 ☐ Could not be	200. Piece of injury - Acti	ome, farr	n, street, fact	ory, office			Street and Numbe	er or Rural Route Number,
ă	5 # E	Certification:	4 Homicide	building, etc. (Speci	ry)				City of 10	wn, siele/	
	To the Hospital or Attand within 24 hours after deat! To the Funeral Director: completely filled in by the	edical		ystcian: To the best of my known the state of the best of examination and menner steted.							
	o the	Me	29b. Signeture and title of certifier			1	9c. Licens			29d. Date signed	(Month, Day, Year)
	- 5 - 0		5 ppr n	D			000	53150		09-0	7-2004
			30. Name end eddress of person who		m 23e) (T	Type, Print)		6441EL	1.	1.37110	RUILLE
			Shaleunmal		TD.	515	BRI	GHHIEL,	o RD	LUTHE	2093
	Sta	te	31. Dete filed (Month, Day, Year)	32. Registar's Sign	ature						
	Registr	ar	357 09	2004	, Ju						1

State of Maryland / Department of Health and Mental Hygiene Reg. No.U U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 7, 2004 4:17 **Physician STERN JEROME** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RUXTON PIKESVILLE NURSING HOME BALTIMORE PIKESVILLE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth JAN 6, Year 949 7. Age (In yrs. last birthday) 6. Sex **Funeral**  Birthplace (State or Foreign Country) Days 1 M 2 □ F Hours Min 55 MD 215-54-9902 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location t0a State 10b. County 10d. Inside City Limits 27 is marked other than "neturel", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1458 GREENBRIAR CIRCLE 21208 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 Is marked other than "neturel", or Itel 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ρ 1 ☐ Yes 2 🙀 No 3 Widowed 4 Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ERWIN S. STERN JEANETTE SCHNITZER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES STERN / BROTHER 629 LEAFYDALE TERRACE - PIKESVILLE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of the Importent: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SHAAREI ZION CEMETERY 9/8/2004 1 4 ☐ Donation 5 ☐ Other (Specify) ROSEDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ogset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but no resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2☐No 2 □ No 1 Yes 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred 26. Place of Death (Check only one, Hospital: 1 | Inpatient Other: 1 Yes 2 No ပ 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funerel Director: the 3 🗌 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 30. Name and address of person ller 31. Date filed (Month, Day, Year) State 0 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 3 1 2004 August 9:00 PM /Medical aurence /urner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1**X** M 2□ F Yrs. Director 8/31/04 None Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City Town or Location 10d. Inside City Limits colling at 1 ☐ Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō the Madigal Exercitive must be 23a Completed by Funeral or Items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Whit 3 ☐ Widowed 4 ☐ Divorced Specify: 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. -fanother traumatic svent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve 19a. Informant's Nam - elationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Richs) //5/70 De/Our

20b. Place of Disposition (Name of cemetery, crematory or other place) Sandra HATHORY MD Kingsville lurner 2108 Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2004 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility . JENKINS & SONS CO. MONETON 23a. Part1. Emer the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nk-now /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): or Attending Physicisn: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 12 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed' 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 1 ☑Natural After t Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending М 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TUNSON, MA 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Physicia		Registrar  1. Decedent's Name (First, Middle			artment of Health an 835 9/10/04 rtificate of Death	2. Date of Dea	th	3. Time of Deat
/Medica				Frederick	Thompson	SEPTEMYS	en 06 200	. 11.000
Examine		4a. Facility Name (If not institution,			4b. City, Town, or Location of D	eath	4c. County of Dea	th
		Union Memori 5. Social Security Number		] a (In yrs. last birthday)	Balto If Under 1 Year   If Under 24		N/A	thplace (State or For
uneral irector		213-14-8829	1 <b>□X</b> M 2□F	82 Yrs.	Months Days Hours	Vin. (Month, Day		Md
3		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Lir
or 28a-f show	ō	Md	N/A	Balto				1 ∑Yes 2 □
r 28a	rec	10e. Street and Number			10f. Zip Code	1	0g. Citizen of What Co	ountry?
23a o	aiD	4800 Yellowwood	l Road		21209		USA	
or items	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent 8 Armed Forces?  1 [X]Yes 2 [ N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P  1 ☐ Yes 2 ▼ No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, White Specify: B	
	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed)  College (1-4or 5	16a. Dece (Give //ife.	odent's Usual Occupation a kind of work done during most of DO NOT use retired)	working	16b. Kind of Business	/Industry N/A
ther t		12th grade  17. Father's Name (First, Middle, L	N/A	A Au	to Mechanic 18. Mother's	Name (First, Middle, I	Maiden Sumame)	
ked o	To Be	Frederick Th	nompson		Ire	ne Rayne		
le ma		19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Maili	ing Address (Street and Number o			Zip Code)
f item 27 I r other tre		Carl Thompson	Son Diothe	1	2 Beech Avenue			T
or of		20a. Method of Disposition 1   Burial 2 □ Cremation			matory or other place)		20c. Location - City or	
Importent: If ite any injury or of socs.	ì	*4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L					Owings Mil: West	ls, Md
any ir	1	Shit	to K- In	nes		-	ie Balto, 1	Md 21215
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lin	the death. Do not en	ter the mode of dying, such as car	diac or respiratory arre	est,	Approximate Interval Between
sician		Immediate Cause (Final disease or condition resulting in death)	a	SEPS15				Onset and Deat
ledical - aminer		1650tting in death)	Due to (or as	a consequence of):	h///			2 DAVS
	Jer	Saquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):				
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trans	ē	that initiated events	c					
	ai Examin	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequence of):				
physicis s the bur	edicai Exar	that initiated events	c. Due to (or as a	a consequence of):				
attending physicie for use as the bur	edicai	that initiated events	d23c. If yes, outcome	of pregnancy 2 □ Fetal death 3 [	□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death SEFTEMBER 7, 2004 **Physician** Andrew Vilagi J. 06:05P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Yrs 297-01-9615 Director 89 30. Ohio Usual Residence of Decedent with the Maryland 10a State 10h Count 10c, City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at **Baltimore** Towson 1 ☐ Yes 2 ☑ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or Items 23a 1015 Valewood Road 21286 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other than "naturel", or item any injury or other treumatic event, the Medical Exemples 2008. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Specialist Noice of America 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vilagi Jerry John Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Eiben 1015 Valewood Road; Towson, MD 21286 nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 9/9/04 <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Towson, MD 21. Signature of unerat Service Licensee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARDIOVASCULAR RESPIRATORY ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BLEEDING DUODENAL MASS Sequentially fist describes if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): burial-Box 68760. physician Physician/Medicai as the attending esn esn IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Po Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe 2 X No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No certificate has burector, page 2 s 2 No 1 ☐ Yes Division of Vital Hospitel or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 10 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes this 27. Manner of Ceath
Natural
2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funerel [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the 29d. Date signed (Mghth, Day, Year) 29b. Signature andrittle 29c. License number D25102 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AYIVA 7505 OSLER DRIVE #307 TOWSON. MARLAND GOLDBERG M. D. 31. Date filed (Month, Day, Year) 32. Regis State 2004 Registrar

P.O. Box 68760

Records,

of Vital

Division

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Dav Yeer 10:40P.M. september 2, 2004 Edward Jr. Williams /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL 61en Burnie Arundel North Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Min X M 2 F Days Hours 216-42-5073 Director March 30 1942 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ?7 is marked othar than "naturel", or items 23a or 28e-f show traumatic event, the Modical Exprimer must be notified at 10d. Inside City Limits Maryland Anne Arundel Pasadena Director 1 ☐ Yes 3/☐ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7716 Lee Drive 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2½ No Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. othar than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Correctional Officer Baltimore City Jail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic •• Edward J Williams Sr. Ruth Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7716 Lee Dr. Janice C. Williams spouse Pasadena MD 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town State 1 □ Burial 2 → Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 9/4/04 Baltimore MD 21. Signatur of Funeral Service Lice 22. Name and Address of Facility Stallings Funeral Home P.A. <u>3111 Mountain Road Pasadena Md. 21122</u> tions the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MASSIVE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician ar for use as the burial-t Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) inpatient ate of Injury Certification: To 1 Tes ij 2 ER/Outpatient 3 DOA uneral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 | Pending death. investigation 1 ☐ Yes 2 ☐ No Diractor: / 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number D43977 person who completed cause of death (Itam 23a) (Type, Print)

FLOT. 39 Hospith Drive, Glon Burne. nn. 10

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician Month Day Year Rosemarie Wills SEPTEMBER 2004 02:53 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Yea 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 💢 F 75 Director 214-24-9860 Yrs Maruland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Baltimore Perru Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9509 A Kingscroft Terrace 21128 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No White 5 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Beauty Salon .. Pages 1 and 2 should ba filed v tment of Health and Mental Hygies tant: if item 27 is marked other ti jury or othar traumatic event, the marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Brocato Margaret Lehr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard Wills 9509 A Kingscroft Terrace, Perry Hall. MD 21128 (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. ` 4 ☐ Donation 5 ☐ Other (Specify) 9/11/2004 Gardens of Faith Baltimore. Maryland 21. Signature of Funeral Service Dicenses 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician disease or condition resulting in death) END STAGE CHRONIC OBSTRUCTIVE /Medical Due to (or as a consequence of): Examiner PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be exacuted as the burial-transit Due to (or as a consequence of): attending physician for use as the burial Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 CORONARY ARTERY DISEASE Completed 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 200 No Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attanding 1 Natural 2 ☐ Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No after death 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Tivi

SEP 0 9 2004

31. Date filed (Month, Day, Year)

7601 OSLER DRIVE TOWSON, MARYLAND 21204
32 Registrar's Signature

# Werman, Frellingel

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			For State Registrar	State of Ma		artment of Health and <b>N</b> <i>rtificate of Death</i>	-	giene Reg. Nø. 🔒 🏳	11. 20616
			Decedent's Name (First, Middle, La	ast)			2. Date of Dea	ath	3. Time of Death
	Physici		Frederick	Werman			Month O9 -	Day	Year O' 199M
	/Medic Examin		4a. Facility Name (If not institution, gir	ve street and number)	<u>-</u>	4b. City, Town, or Location of Death	01.	4c. County	01 0 11
	Exami	•	Franklin Square 1	tosotal Cen	Ler	Rosedale.		Pol	timore
	Funeral	9	5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Dete of Birt (Month, Da	h v Voer)	Birthplace (State or Foreign Country)
	Director		126-05-0056	1♥M 2□F 8	34 Yrs.	Months Days Hours Mill.	Aug. 16	,1920	New York
	p s		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Le	and the same of th			10d. Inside City Limits
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	the N	ect	Maryland Baltimo	re		Baltimore 101. Zip Code		10- 08	^
	with a or :	Funeral Directo	7 Chapeltowne C.	inala		21236		10g. Citizen of \	
:	eath rs 23	eral	11. Marital Status	12. Was Decedent E	ever in U.S. 13		ecify Ves or No.	14 Bac	U.S.A.
	ter d	'n	1 ☐ Never Married 2 ☑ Married	Armed Forces?	lo 110.5.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Blac	ck, White, etc.
33	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	1 🕅 Yes 2 🗆 N If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify:		Specify	v: White
5-0036	2 ho	ted	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Occupation		16b. Kind of B	usiness/Industry
21	e.	npie	Elementary/Secondary (0-12)	College (1-4or 5-	+) life.	kind of work done during most of work DO NOT use retired)	li i g		
21	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23s or 28s-f show ent, Ite Macilcal Examiner must be notified at	Completed	12th Grade		Shee	t Metal Worker			al Mills
ב יי	be fill d off d off	Be	17. Father's Name (First, Middle, Las.			18. Mother's Nam			ne)
aryland 2121	should be nd Mental marked o umatic eve	၉	George Werma			Josephi		Barsch	
	2 sh and ls rr ls rr		19a. Informant's Name/Relationship			ng Address (Street and Number or Run			
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altimore,	permit. Pages 1 a Department of Hee Importent: If item any injury or othe anca.		1 Burial 2 X Cremation 3			matory or other place)			City or Town, State
	t. Partmer		' 4 □Donation 5 □ Other (Special						re, Maryland
Ba	permit. Pages Department of Importent: If ii any injury or once.		21. Signature of Funeral Service Lice	DIN O		2. Name and Address of Facility SC			
			23a Part 1 Enter the disease or con	andications that caused		9705 Belair Rd., B	uccumon	.e, MU 2	1230
			shock, or heart failure. List only		the death. Do not en	ter the mode of dying, such as cardiac	or respiratory ar	rect	T. T
	Physician /Medical			one cause on each lin	θ.	ter the mode of dying, such as cardiac			Approximate Interval Between Onset and Death
			Immediate Cause (Final disease or condition resulting in death)	a. Abril'e	Sclerus				Approximate Interval Between
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. Box 68760,	death certificate be executed e attending physician and of for use as the burial-transit		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	b Due to (or as a d	Sclerude a consequence of):  a consequence of):  a consequence of):  a consequence of):	Cardiovascu		ksea se	Approximate Interval Between Onset and Death
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P.O. Box 68760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	b. Due to (or as a d	a consequence of):  a consequence of):  a consequence of):  a consequence of):  of pregnancy  Consequence of the consequence of	Lation  Dectopic pregnancy Other (specify)	23e. Did to	23d. Dai Mo	Approximate Interval Between Onset and Death  te of delivery nth Day Year
ecords, P.O. Box 68760,	iv requires that the death certificate be executed to be some signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a d	a consequence of):  a consequence of):  a consequence of):  a consequence of):  of pregnancy  Consequence of the consequence of	Lation  Dectopic pregnancy Other (specify)	23e. Did to 1 4 24a. Was autop	23d. Dai Mo	Approximate Interval Between Onset and Death  te of delivery onth Day Year  ribute to the cause of death?  3 Probably 4 Aunknown  Were autopsy findings available prior to completion of cause of
Records, P.O. Box 68760,	iv requires that the death certificate be executed to be some signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a d	a consequence of):  a consequence of):  a consequence of):  a consequence of):  of pregnancy  Consequence of the consequence of	Lation  Dectopic pregnancy Other (specify)	23e. Did to	23d. Dai Mo	Approximate Interval Between Onset and Death O
Records, P.O. Box 68760,	iv requires that the death certificate be executed to be some signed by the attending physician and should be detached for use as the burial-transit		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underflying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a d	a consequence of):  a consequence of):  a consequence of):  a consequence of):  of pregnancy  Consequence of the consequence of	Cardibuaseu  Nation  Dectopic pregnancy Other (specify)  Inderlying cause given in Part I.	23e. Did to 1 yes	23d. Dai Mo  bbacco use cont  'es 2 \ No  an 24b. \ sy y	Approximate Interval Between Onset and Death  te of delivery inth Day Year  ribute to the cause of death?  3 Probably 4 Munknown  Were autopsy findings available prior to completion of cause of death?
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of Vital Records, P.O. Box 68760,	Physicien: The law requires that the death certificate be executed: this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a b Due to (or as a c.  Due to (or as a d.  Due to (or as a d.  Due to (or as a d.  23c. If yes, outcome of the contributing to death but the contribution of the	Sclerude of: a consequence of): b consequence of): a consequence of): a consequence of): a consequence of): a consequence of): b consequence of): a consequence of):	Cardibuaseu    Cardibuaseu   C	23e. Did to 1 yes 24a. Was autop perfor 1 yes n (Check only or	23d. Dai Mo  bbacco use cont  'es 2 \  No  an 24b. 1  symmed? 25 No  ne)	Approximate Interval Between Onset and Death  te of delivery onth Day Year  ribute to the cause of death?  3 Probably 4 Hunknown  Were autopsy findings available orior to completion of cause of death?  1 Yes 2 No
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of Vital Records, P.O. Box 68760,	trending Physicien: The law requires that the death certificate be executed death.  death.  After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Dther significant conditions  Huperten Sid No  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural 5   Pending	Due to (or as a d. Due to	a consequence of):  a cons	Cardibuaseu	23e. Did to 1 yes  24a. Was a autop perfor 1 yes  1 (Check only or me 5 Resid 28d. Describe h	23d. Dai Mo  Disacco use cont  Ves 2 No  an 24b. Ves  syymed? 2 No  ne)  lence 6 Oth  low injury occurr  Street and Numb	Approximate Interval Between Onset and Death  te of delivery onth Day Year  ribute to the cause of death?  3 Probably 4 Hunknown  Were autopsy findings available orior to completion of cause of death?  1 Yes 2 No
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Macda' Chardon, 7845 bakwood lo Stello Gleu Burnie, Mo

31. Date flied (Month, Day, Year)

SEP 0 9 2004

SEP 0 9 2004

SEP 0 9 2004

Registrar

056979

Certificate of Death

2. Date of Death

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

21133-4784

5 mmths

Year

Month

1 Yes

Day

3 ☐ Probably 4 ☐ Unknown

2 🗆 No

Approximate Interval Between Onset and Death

Baltimore,

3:30 A M

MD

Month Day 2004 Carolyn McDonough Windsor /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockdale
If Under 1 Year If Under 24 Hrs. 8406 Maymeadow Court Baltimore 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 M 2 F Director June 15,1925 79 214-20-5735 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County ral, or items 23a or 28a-f show Examiner must be notified at Rockdale Baltimore Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 8406 Maymeadow Court 21244 <u>United States</u> death by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or Itel
sny or other traumatic event, the Musical Examinatiny or other traumatic event, the Musical Examinatiny. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Martin Marietta 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank J. McDonough Madeleine Blankford ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8406 Maymeadow Court, Rockdale, MD. 21244 Mrs. Susanna Rodney 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If Ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 21207 Lorraine Park Cemetery 09/11/04 22. Name and Address of Facility Loring Byers Funeral Directors Inc 21. Signature of Funeral Service Licensee Collner M00333 8728 Liberty Road, Randallstown, MD. 23a. P.m. Enter the discussion or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed the attending physician and the for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the a ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 ENG Completed should peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No has 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ After this in by the funeral 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 DMatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/200

State

31. Date filed (Month, Day, Year)

For State Registrar

Physician

1. Decedent's Name (First, Middle, Last)

Suite

32. Registrar's Signature

PILLEVILLE

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** JAMES WALLACE 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HUSPITAL BACTIMORE YERCY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Day, Year) | April 26, 1965 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** California 1 M 2 □ F 39 Yrs. 555-65-8428 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f show other treumetic event, the Medical Exertangual be notified at 1 ☐ Yes 2 X No Director Rancho Santa Margarita CA Orange 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or Items 23a or 61 San Sebastian 92688 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. s filed within 72 hours after if Hygiene. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: þ white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Student Pilot Training 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked ofth eny injury or other treumetic event, 2008. 17. Father's Name (First, Middle, Last) Be James LeRoy Wallace Darlene Conver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 61 San Sebastian; Rancho Santa Margarita, CA 92688 ace of Disposition (Name of Date 20c. Location - City or Town, State Darlene C. Wallace / mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State Hilltop Service Corp. 9/8/04 \* 4 ☐ Donation To ☐ Other (Specify) Towson, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licens 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Negative hRS Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ strophic 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ 100 certificate has b Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28h Time of 28c. Injury at Work? Certification: After Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. after death Director: 6 Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c\License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST PAUL PLACE BALTIMORE NO 301 32. Registrats Signature 31. Date filed (Month, Day, Year) State 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** September one 2004 8.29 A M Carl Marvin Wheeler /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital 6. Sex Baltimore Muryland SIMAI If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months **X**OM 2□ F Director 212-42-8088 07 06 43 MD Usual Residence of Decedent the Maryland 10a State show 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28e-f show Director XXYes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 3005 Oakley Ave 21215 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or other traumatic event, the Madical Examples 2 should be filed within 72 hours after of and Mental Hygiene. is marked other than "netural", or Iter I ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 Yes 2XXVo Specify þ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Mail Carrier U.S. Postal Service 3yrs 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ဂ James M. Wheeler Marion Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. 3005 Oakley Ave, Baltimore, Md Shirley E. Cooper-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Garrison Forest Vet. 9/9/04 Owings Mills 21. dignature of Tuneral Service II 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardiac Physician disease or condition resulting in death) 5 mcts /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter unuerlying Cause (Disease or injury Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last certificate be exec Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1pertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed abetes 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has Vascular reripheral 15easo 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပို 1 Yes 2 No 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide in by t Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Hospital 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) the 29b. Signature and Atle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 21730 1.04 an 3X1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belvedere Avenue Balto, Md 21215 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 0 9 2004 Registrar

Please T	ype or Print in Black Indelible Ink. E	insure All Copies Are Legible.
	State of Maryland / Department of Hea	llth and Mental Hygiene
	Certificate of De	eath Reg. No.?
e (First, Middle, Last)		2. Date of Death Month Day Year

		For State	State of Maryla		irtment of H				001	0000	
Physic		Registrar  1. Decedent's Name (First, Middle, Last GEORGE J.	WILLNER	001	imouto or i		2. Date of De	ath Day	2°04	3: Time of Dea	p <sub>M</sub>
/Med Exami		4a. Facility Name (If not institution, give FRANKLIN SQUARE		ENTER		EDALE		4c. C	ounty of Death	ORE	
Funeral Director		217-10-0249	x 7. Age (In yrs	82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h y. Yea <i>r)</i> 922	9. Birth Cou MA	place (State or Fo ntry) RYLAND	reign
ith the Maryland or 28a-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD HARFO		City, Town or Lo		NGDON				10d. Inside City Li 1 ☐ Yes 2 ☐	
h with the	al Director	10e. Street and Number 307 A TALL PINES	COURT		10f. Zip Code 2	1009	1	10g. Citize	U.S.		
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within 72 hound.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	lent's Usual Occup kind of work done of DO NOT use retired	du <i>ring</i> most of wo			of Business/Ir	ndustry	C
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C, IVICILY ICA	1	19a. Informant's Name/Relationship (7) EMELINE WILLNER/			ng Address (Street a			GDON ,		o Code) 1009	
Deficiency of the permit. Pages 1 and Department of Heal Important: If Item 2 eny injury or other pages.		20a. Method of Disposition  1 X Burial 2 Cremation 3   4 Donation 5 Other (Specify	Removal from State		sition (Name of natory or other place L CEMETE		Date 5-2004		ation - City or T		
permit. Departm Importa eny inju		21. Signature of Funeral Service Licens	ee Its		. Name and Addres					L HOME 1237	
Physiciar /Medica		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the de ne cause on each line.  a		er the mode of dyin	g, such as cardia	ac or respiratory a	rest,		Approximate Interval Between Onset and Deat	th
certificate be executed certificate be executed diring physician and use as the burial-transit	dicai Examiner	Sequentially list conditions, the representation of the land of th	b. Due to (or as a consect.  Due to (or as a consect.)  Due to (or as a consect.)	equence of):							
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To the Hospitel or Attending Physicien: To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ertification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1	y at k? Yes 2 □ No		Street and		ral Route Number,	
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× 5	tate	31. Date filed (Month, Day, Year)	2004 32. Redistrar's Sig	mature	Joseph						

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Maryland 21215-0036  of 2 should be filed within 72 hours after death with the Maryland that Mental Hygiene. Ith and Mental Hygiene. Z7 is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at	by Fu	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 □Yes If Yes, Gi Year or D	Ve	Ì	1 🗆 Yes		Specify:	10 / 110 211, 010.)		Specify: Wh	-
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Page nent of Int: If	3	1 ☐ Burial 2 🔀 Cremation  4 ☐ Donation 5 ☐ Other (Sp		State	Metropo Metropo Crema		n piace	, , .	004	Alex	xandria	, Virginia
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other than "naturel; or Items 23a or 28a-1 show any injury or other traumatic event, the Wedical Examinat must be notified at ones.		21. Signature of Funeral Service L	censee	e.	$\mathbf{F}_{1}^{22}$	Name an	g Address ivers	Collins sity Blv	Funerad, W.,	al Ho Silv	me Inc	ing, MD 20
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30 duly		30. Name and address of person w	no completed caus	e of death (Iton	n 23a) /Tuno 5	Print)						

			1 = For State Ragistrar	State of	Marylan		artmen rtificate				lental Hy			
			Decedent's Name (First, Middle, La.	st)			incatt	o or i	Jeaur		2. Date of De	Reg. No.	<del>) ()  </del>	7 3 C 7 2
	Physic		Gertrude 01	,	accen						Month	Day	Year	
	/Medi Examir		4a. Facility Name (If not institution, give				4h City	Town or	Location of	of Death	August		ounty of Death	8:05A M
	Exami	101	Rockville Nursin		,			ckvi		o. 004				
	Funeral		5. Social Security Number 6. S		. Age (In yrs. I	ast birthday)	If Under	1 Year	If Under		8. Date of Bir	th P10	ntgome	place (State or Foreign
	Director		050-05-1923	□M 2 <b>∏</b> F	86	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Jan. 1	9.19	18 Nev	Intry) York
	pu ,		Usual Residence of Decedent											TOTA
	anyla shov	-	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Ba-f	Director	Maryland Montgom	ery		R	ockvi							1 ☐ Yes 2 ☒ No
	with t	D.	10e. Street and Number 14424 Parkvale R	1			10f. Zip					10g. Citize	n of What Cou	intry?
	death with the Maryland ms 23a or 28a-f show f must be notified at	Funeral				1 10		208					ed Sta	
	Item Item	ů	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li></ul>	12. Was Decede	es?	s. 13.	Was Deced If Yes, spec	ent of Hi ify Cuba	spanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	- 14.	<ul> <li>Race - Amer</li> <li>Black, White</li> </ul>	ican Indian, , etc.
36	Irs af	by F	3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date			1 □ Yes 2	2⊠ No	Specify:			S	pecify: W1	nite
21215-0036	72 hours after natural', or Ite	ted	15. Decedent's Ed	lucation	-	16a, Dece	dent's Usua	I Occupa	ıtion			16h Kind	of Business/li	
215	7 nin 7. n. nin	Completed	(Specify only highest gra	de completed)	las E.V	(Give life.	kind of wor. DO NOT us	k done d e retired	uring mosi	t of worki	n <i>g</i>	TOD. KING	OI BUSINESS/II	ldustry
212	d with giene ar tha	E O	12	College (1-4	10r 5+)		maker					(	Own Hor	ne
	al Hy othe vant,	ВеС	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,			
/lai	uld b Venta rrkad rtic a	70 E	Peder Albert Pe	dersen					Ger	rda E	ckerho	vdt		
Maryland	sho and h s ma		19a. Informant's Name/Relationship (7			19b. Mailir	g Address	(Street a	n <i>d Numb</i> e	r or Rura	l Route Numbe	er, City or T	own, State, Zi	o Code)
Σ	and 2 salth n 27 i		Carol Andreassen/	Daughter	T.	3009	Fayet	te R	oad,	Kens	ington	, Mary	yland 2	20895
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23s or 28a-f show amportant: If you provide a show a provided the real metric avant, the Madical Examinet must be notified at an once.		20a. Method of Disposition	D		ace of Dispo	sition (Nam	e of		D	ate		tion - City or T	
Ĕ	G F F P		1 ☐ Burial 2 ☑ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify		ate	gomery	-		. 14	.ugus 200	t 21,	Bethe	sda, Ma	rvland
alt	permit. Departr Importa any inj		21. Signature of Funeral Service Licen	see	·	22	Name and	Addres	s of Facility		· · · · · · · · · · · · · · · · · · ·	77	/D 1	lle, Inc.
8	90 E 9		Kay Jan		M001	L98 300	West	Mon	tgome	ry A	ve., Roc	Home/ kvill	ROCKVI e. MD 2	lle, Inc. 0850-2805
			23a. Part1. Enter the disease, or companies, or heart failure. List only	olications that cau	sed the death.	Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Hype	ertensi	ve He	art D	isea	92					Onset and Death
	/Medical Examiner		resulting in death)		as a conseque		are D.	1004	<u> </u>					
	Examiner		Sequentially list conditions,		ipheral		ular I	Dise	ase					
	Se se	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	ав а солведы									
	and I-tran	хап	that initiated events resulting in death) Last		onary A		Disea	ase						
68760,	eath certificate be executed attending physician and for use as the burial-transit	E			as a conseque entia	ance or):								
387	phys the	edicai		d										
×	certif iding ise as		IF FEMALE:	23c. If yes, outcor	me of pregnan	CV								
Вох	death certi e attending id for use a	Physician/M	in the past 12 months?	1 Live birth	n 2 ∏Fetal o	death 3 🗆	Ectopic pre Other (spe					23d.	<ul> <li>Date of delive</li> <li>Month</li> </ul>	Day Year
P.O.	that the de led by the detached	ıysi	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unknow		3	Ottroi (app	C y /						
	law requires that the as been signed by th 2 should be detache	y P	Part II. Other significant conditions co	intributing to deat	h but not result	ting in the un	derlying ca	use give	n in Part I.		23e. Did to	bacco use	contribute to the	ne cause of death?
Vital Records,	quires n sign	d by									1 🗆 Y	es 2□N	lo 3 Prob	ably 4 XUnknown
Ö	w requi	Completed									24a. Wasa	- 0	Ale Mare ent	
Re	0 L 0	mc		•							autop	sy	prior to condeath?	psy findings available inpletion of cause of
ta		C	25. Was case referred to medical				_				1 Yes	2X No	1 🗆 Yes	2 No
5		o B	examiner?	Hospital:	atient 2□E	P/Outpotions	27.004	Othor			(Check only or		_	Town No.
		-	27. Manner of Death	28a. Date of I	njury 2	28b. Time of		c. Injury	4 <u>K</u> Nur		e 5 🗆 Reside			/)
on	토호교	틶	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, I	Day Year)	Injury	м	Work's	es 2.⊟N			,,		
Division	or Attending after death. Diractor: After in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of	Injury - At hom	ne, farm, stre	et, factory,	office		21	Bf. Location (Si	reet and No	umber or Rura	l Route Number.
-	2 8 5 5	ert	4   Hornicide	building,	etc."(Specify)					Į.	City or Town	n, State)		
	pspit hours inera y fille		29a. Certifier 1X Certifying Phy	sician: To the be	st of my knowl	ledge, death	occurred at	t the time	, date and	place, ar	nd due to the c	ause(s) and	manner as st	ated.
	ha Ho n 24 na Fu	edicai	(Check only 2 Medical Exam	ner: On the basis and manner	s ot examinatio	on and/or inv	estigation, i	n my opi	nion, death	occurre	d at the time, d	ate and place	ce, and due to	the cause(s)
	To tha Hospital of within 24 hours af To tha Funeral D completely filled in		29b. Signature and Title of certifier		. 0	,	29c.	License	number	·	2	9d. Date sig	gned (Month, i	Day, Year)
)	2		I drom	ins 1	1-1103	414		D47	330			Augu	st 19,	2004
	/		30. Name and address of person who c		of death (Item 2	(Type, F	rint)							
			Thomas V. Joseph,	M.D. 5	0 West	Edmon	ston	Driv	e, #2	207 F	Rockvi1	le, Ma	aryland	1 20852
	Sta Registra		31. Date filed (Month, Day, Year)  AIIG 23 200	32. Regi	strar's Signatu		1	1/1						

			1- State of Maryl		partment of h ertificate of		lental Hy	_		
			Registrar  1. Decedent's Name (First, Middle, Last)		erinicale or	Deaui	2. Date of De	Reg. N	10.200 H	3. Time of Death
п	Physicia	an		11amy			Month	D	ay Year	
)	/Medic		4a. Facility Name (If not institution, give street and number)		4b City Town o	r Location of Death	August		2004 c. County of Deal	7.50
	Examin	er	Mariner Health Care of Greate	r Laure		. 2004.017 01 004.17			rince Ge	
_	Funeral			yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Bit	rth	9. Birl	hplace (State or Foreign
Ü	Director		219-10-9081 <sup>1□M 2</sup> √ 80	Yrs	Months Days	Hours Min.	Dec. 2			rgetown,SC
	D.		Usual Residence of Decedent						10001	gecown, bo
	irylar show	_		. City, Town or						10d. Inside City Limits
	Ba-f a	5		eltsvil	.le					XXYes 2□No
	ith th	Director	10e. Street and Number		10f. Zip Code			10g. C	Citizen of What Co	ountry?
	ath w	Ta .	5332 Brewer Road		20705			Uni	ted Stat	
	er de	Funerai	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 1	<ol> <li>Was Decedent of F If Yes, specify Cubi</li> </ol>	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whit	
36	s aft		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give A 3 € Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2√ No	Specity:			Specify Bla	ck
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Ital Hygiene. Italian "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	15. Decedent's Education	16a De	cedent's Usual Occup	nation		16h	Kind of Business/	
5	in 72 n "na	olet	(Specify only highest grade completed)	(G.	ive kind of work done  DO NOT use retire	during most of work	ang	100.	Mild of Business	Modelly
7	with iene.	E o	Elementary/Secondary (0-12) College (1-4or 5+)	Но	memaker			Dor	nestic	
0	i Hyg othe	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle			
Maryland	lid be lenta ked lic ev	To B	Edward McCullough			Ethel Pi	nno			
ary	shou and N ama uma		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street	and Number or Rur	al Route Numb	er, City	or Town, State, 2	Zip Code)
	alth a		Cozette Talib/ Daughter	5332	Brewer Ro	l. Belts	ville,	MD 2	20705	
e,	os 1 a			b. Place of Dis	sposition (Name of rematory or other place		Date		Location - City or	Town, State
Ĕ	Page nent a		1 Sp Burial 2 ☐ Cremation 3 ☐ Removat from State  4 ☐ Donation 5 ☐ Other (Specify)		oln Cem.	8/25	/2004	Bre	entwood,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Sports Licensee		22. Name and Addre	ss of Facility	1 17.000.0			**
m	88 5 8				Ft. Lincol 3401 Blade	ensburg Ro	l Home 1. Bren	two	od, MD 20	0722
10.			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.							Approximate Interval Between
	Physician	}	Immediate Cause (Finat disease or condition Alzhier							Onset and Death 1Year
	/Medical		resulting in death)  Due to (or as a con	sequence of):					-	11001
	Examiner		Sequentially list conditions, b.							
= 2	D #	ner	rf any, leading to immediate  Cause. Enter Underlying	sequence of):						
	acute ind trans	Examiner	Cause (Disease or injury that initiated events c							
ő,	e exe sian a urial-	<u>m</u>	resulting in death) Last Due to (or as a con	sequence of):						
8760,	cate be executed physician and the burial-transit	dlcal	d							
9	entific ling p	Me	IF FEMALE:	A.(196	<del> </del>					
Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	Fetal death	3 DEctopic pregnancy	1			23d. Date of del Month	ivery Day Year
o.	the a	ysic	1 ☐ √es 2X No 4 ☐ Pregnant at time 9 ☐ Unknown	of death	5 Other (specify)					,
Δ.	that the de ed by the a detached f	P.	Part II. Other significant conditions contributing to death but not	resulting in the	underlying cause giv	en in Part I.	23e. Did 1	tobacco	use contribute to	the cause of death?
ds,	signed be det	d by	Cerebrovascular Accident		,					obably 4 🖸 Unknown
Ö	w require been si should I	Completed								
ž	has has	du					24a. Was	psy ormed?	prior to death?	topsy findings available completion of cause of
a							1 ☐ Yes	2 <b>X</b> N		2 No
of Vital Records,		Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 № No  Hospital: 1 ☐ Inpatient	- D 5510 · · ·	ingt 20 DOA Oth	26. Place of Deat				
o	Phys r this ral di	: To	27. Manner of Death 28a. Date of Injury	2 ER/Outpat	IGHT 3L DOX	4 Ku Nursing no	ome 5 ☐ Resi 28d. Describe		6 Other (Spec	cify)
Division	Attending as death.	Certification:	1 型 Natural 5 □ Pending (Month, Day Yea 2 □ Accident investigation	r) Injur	y Wor	k? Yes 2 □ No			,	
/isi	l or Attendatter deatt	flca	3 Suicide 6 Could not be 28e. Place of Injury -	At home, farm,			28f. Location (	Street a	and Number or Ru	ıral Route Number.
ā	after after Dire	erti	4 Homicide determined building, etc. (Sp	pecify)			City or To	wn, Sta	te)	
	To the Hospital or within 24 hours afte To the Funeral Dis completely filled in		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, de	eath occurred at the tir	ne, date and place,	and due to the	cause(	s) and manner as	stated.
	ne Ho	edical	(Check only one)  2 Medical Examiner: On the basis of examiner and manner stated.	nination and/or	investigation, in my o	pinion, death occur	red at the time,	date ar	nd place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. D	ate signed (Monti	n, Day, Year)
			) the	M.	D	24721		Α	ugust 25	2004
	00 12		30. Name and address of person who completed cause of death	(Item 23a) (Typ	pe, Print)					
-(	1-13		Syed Akbar Sadiq, M.D.,F.A.	C.P. 1	4333 Laure	1 Bowie F	Rd St 20	08 L	aurel MI	20708
27	Sta		31. Date filed (Month, Day, Year) 82. Registrar's S							
	Registr	-210	AUG 2 7 2004 Beeter	F God	We .					
DL	MH 17 Pay 1/2	101		-						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) -3. Time of Death Day Year **Physician** Josephine Branson SEPTEMBER 3 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jul 6, 1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🙀 F Director 217-10-6285 86 Usuel Residence of Decedent the Maryland 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at WV Mineral Ridgeley 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a Rt. 1 Box 51 26753 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white À Specify: 3X Widowed 4 ☐ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 73 h and Mental Hygiene 7 Is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) owner/operator Greenhouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harper Peer Eva White Peer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or othar treum <u>once.</u> JoAnn Neppl Rt. 1 Box 51 daughter Ridgeley WV 26753 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Fort Ashby Cemetery 9/5/2004 Fort Ashby WV \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Pert1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pancreatic Carcinoma Physician 2 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician P.O. Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 No 0 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe SEPTEMBER D14865 James olous Wales 30. Name and address of person who completed cause of death (Item 23a Type, Print) MEMORIAL MEDICAL BLDG., 500 MEMORIAL AVE., CUMBERLAND, MD ROBUSTIANO BARRERA. DR.

State Registrar

32. Begistrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1	For State Registrar  1. Decedent's Name (First, Middle, Las	4)	•	•	icate of L	eaith and in Death	2. Date of D	Reg. No.	04	O C O C
Physician	n	. Decedent's Name (First, Mildore, Las	<sup>"</sup> Joan Anne	tte Bars	ky			Month August	Day	2004	9:15 P
/Medica Examine		la. Fecility Name (If not institution, give	street and number)		41	•	Location of Death			unty of Death	
		Suburban Hospita				Bethes		T	1	fontgom	
Funeral Director		578-34-8794	9X 7. Age □ M 2 🕅 F	74 Yr	M	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D Oct. 23	$\frac{1}{3}$ , $\frac{Y_{\theta ar}}{1929}$	9 Birthi Coul	place (State or Foreigntry) York
land and	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	or Locati	on					10d. Inside City Limit
Mary -feh	ţō	Maryland Montgom	ery	Silv	er S	Spring					1 ☐ Yes 2 🖺 N
h the	lrec	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?
th with	ai	3752 S. Leisure W	orld Blvd.			209	06		Unite	ed Stat	es
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 show any injury or other traumatic event. In the World Examiner must be notified at once.	by Fur	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent If Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	Ever in U.S.		Decedent of Hi es, specify Cubar Yes 2K No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or N Rican, etc.)		Race - Ameri Black, White, ecify:	
Maryland 21215-UU30 td 2 should be filed within 72 hours aft lith and Mental Hygiene. 77 Is marked other then "naturel", or traumatic event, the Modeal Exam	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5	(6 h	Give kin life. DO		ition uring most of work	king		of Business/In	
ed will	5	12		An	alys	st	40.14.15.1.11		<del></del>	S. Navy	7
be fill be fill dott	Be	17. Father's Name <i>(First, Middle, Last)</i> W <b>illiam</b> F					18. Mother's Nam T. 111	ie (First, Middle Lian Co		mame)	
d Mer marke	၉	WIIIII F  19a. Informant's Name/Relationship (		19h A	Mailing A	ddress /Street a	nd Number or Ru			wm State Zin	Code)
and 2 si aulth an n 27 Is r	1	Norris Barsky, So		454	9 N	. Chelse	a Lane,	Bethes	da, MD	20814	+
permit. Pages 1 ar Department of Hea mportant: if Item: any injury or other ance.		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of D cemetery, Mt. Leb	cremati anoi	on (Name of ory or other place n Cemete	ery 08/2	Date 23/04		ohi. MI	
mit. ppartm porta y inju		21. Signature of June, #3an ice Licer	sõe		Tore	ame and Addres	s of Facility Hebrew E	uneral	Home		
8358 0					254	Carrol1	St. NW	. Wash	ington	DC 2	20012
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. Do no ne.	t enter t	he mode of dying	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
Pnysician		Immediate Cause (Final disease or condition	a. Pu	Imonar	V	Embo	lism				< 1 day
/Medical Examiner		resulting in death)	Due to (or as	lmanar a consequence of hemic	):						
	<u></u>	Sequentially list conditions,	b. That of the	hemic	La	rdiom	yopathy				
ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	333 13 (21 22		<i>y</i> . –		•				
ifficate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of	):						
ficate be ex physician as the burial	edicai E		d								
tificat ig phy as th	led.			-							
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death		topic pregnancy ther (specify)			23d	Date of delive Month	ery Day Year
that if		Part II. Other significant conditions of	ontributing to death b	ut not resulting in t	the unde	rlying cause give	n in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
uires n sign	d by							1 🗆	Yes 2	lo 3 □ Prol	bably 4 Unkno
law requires that as been signed to a should be	ompleted							24a. Wa		4b. Were auto	ppsy findings availa
The lar	omp								opsy formed? 2 No	death?	mpletion of cause of
	O	25. Was case referred to medical					26. Place of Dea				
99 10 75	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	ent 2 ER/Outp	atient	3□ DOA Othe	er: 4 🗆 Nursing H	ome 5 Res	sidence 6	Other (Special	fy)
ding Phy h. After thii funeral c		27. Manner of Death  1 Matural 5 □ Pending	28a. Date of Inju (Month, Da		me of ury	28c. Injury Work	at ?	28d. Describe	how injury of	curred	
I or Attending after death. Director: After lin by the fund	atic	2 Accident investigation				M 1 []	/es 2□No				
or Attend after death Director:	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of inj	ury - At home, farn c. (Specify)	n, street	, factory, office		28f. Location City or To	(Street and N own, State)	umber or Rur	al Route Number,
	Medical C		ysician: To the best niner: On the basis o and manner st	examination and/							
o the o the	Me	29b. Signature and title of certifier	, 1)			29c. License	number		29d. Date si	gned (Month,	Day, Year)
(10)		Yet W.	i'Chan	MD.		DO	0507	48	Augu	st 2	2,2004
10		30. Name and address of person who	completed cause of d	leath (Item 23a) (T	уре, Ргі				J		
10		8600 Old Ge	argetow.	Road.	Be.	•					
		31. Date filed (Month, Day, Year)		ar's Signature							

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

Helen Lucille Bennett

4a. Facility Name (If not institution, give street and number)

4b. City, Town, or Location of Death

2. Date of Death Month

August 19,

Day

Yeer

2004

4c. County of Death

3. Time of Death

1:50

 $\mathbf{p}^{\mathsf{M}}$ 

		Randolph Hills	6. Sex	7. Age (In yrs. la:	na brindh da cil	Whea If Under 1		If Under 2	A Hrs a	Data of Bi	rth P10	ontgome	ery irthplace (State or Foreign
Funeral		5. Social Security Number 196-18-3548			Days	Hours	Min.	Date of Bi (Month, D Mar •	ay Year)	9.5 D	Country)		
Director		Usual Residence of Decedent	1□ M 2∏ F	79	, ,,,,,,		İ			al.	, 1	. J 2 J F	enńsylvania
and		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
Aaryl Fsho	ō	Virginia Arli	ington	λ16	xandr	·ia							1 ☐ Yes 2 ☐ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and Leading and 200ce.	Director	10e. Street and Number		AIC	Adnar	10f. Zip (	code				10a. Citi	zen of What C	Country?
with a or	٥			_									•
se 23	era	309 Yoakum Par		4 edent Ever in U.S	13 1	Was Decede	304	soanic Orio	in? (Specif	v Yes or N	0-	USA 14 Bace - Am	rerican Indian,
ter d	Funeral	11. Marital Status  1 □ Never Married 2 □ Marri	Armed Fo	rces?	.   10.1	f Yes, specif	y Cubai	n, Mexican	Puerto Ric	can, etc.)		Black, Wh	
permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exampance.	by	3 XWidowed 4 ☐ Divorced	If Yes. Gir	/8		1 ☐ Yes 2:	No	Specify:				Specify: Wh	ite
ture ature	ed	15. Decedent	t's Education		16a. Deced	dent's Usual	Occupa	ation			16b. Ki	nd of Busines	s/Industry
nin 72 nin ni	ple	(Specify only highes Elementary/Secondary (0-12)	college (	1.40(54)	(Give life. l	kind of work DO NOT use	done d retired)	lu <i>ring m</i> ost )	of working				
y with	Completed	12	Conage (	1.401.54)	Hom	emake:	r					Own Ho	me
ent,	BeC	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name (/	First, Middle	e, <i>Maid</i> en	Sumame)	
lid be lenta ked ic ev	To B	Blake Horner						Let	a Spa	anglei	<u>-</u>		
shour nd M		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (	Street a	ın <i>d Numb</i> e	r or Rural F	Route Numi	ber, City o	r Town, State,	Zip Code)
nd 2 lith a 27 is		Michael Benne	tt/ Son		309	Voaku	n Pa	rkway	, #81	1.4 57	ovar	dria	VA 22304
Hea Hea item otha		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name	of of	_	Dat	6		cation - City o	
ages ant of tr: # :		1 ★Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State E		matory or oth wn Mei	nori	${ ilde{a}}$ l $^{F}$	ugust) 2004		Doole		Arnestal - un d
artme ortan injur		21. Signature of Funeral Service				rk . Name and	Addres	s of Facility		•	ROCK	viile,	Maryland
Deportant any any and and any any any any any any any any any any		Dian	19:1	lon								e Inc.	MD 2006
8		23a. Part1. Enter the disease, or	complications that of	aused the death.								er spr	ing, MD 2090
		shock, or heart failure. List	only one cause on e	each tine.	DO HOL OIL	01 110 1110 00	or oy mig	g, 000/1 00		oop.i.d.o.y	411001,		tntervat Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a Alzhe	eimer's 1	Dement	tia							Years
/Medical Examiner		resulting in death)	Due to	(or as a conseque	ence of):								
Examine	_	Sequentially list conditions,	b		- 6								
D is	ine	cause. Enter Underlying Cause (Disease or injury	Due to	or as a conseque	ance of								
acute Ind trans	Examiner	that initiated events resulting in death) Last	c	<b>/</b>									
e exe		resulting in dodairy case	Due to	(or as a conseque	ence or):								
ate b hysic lhe b	Ica		d			<del> </del>							
the death certificate be executed y the attending physician and iched for use as the burial-transit	Physician/Medical	IF FEMALE:											
ith ce	an/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	tcome of pregnan pirth 2 🗌 Fetat o	death 3	Ectopic pre					1	23d. Date of d Month	elivery Day Year
edea	SICI	1 ☐ Yes 2 ☐ No	4☐Pregr 9☐ Unkn	nant at time of dea	ath 5	Other (spe	cify)					Widiti	Duy Tou
that the de ed by the a detached f	hy	9 Unknown											
law requires that as been signed b 2 should be deta	þ	Part II. Other significant condition	ons contributing to d	eath but not resul	ting in the ui	nderlying ca	use give	en in Part I.					to the cause of death?
en si	ed	Cachexia								1	Yes 2	Z No 3 □ F	Probably 4 Unknown
aw requisite been 2 should	Complet									24a. Wa auto			autopsy findings available completion of cause of
The re h	Eo			-						peri	ormed?	death?	es 2 No
ician: T certifical ector, p	0	25. Was case referred to medical						26. Place	of Death (	Check only			
Physician: this certific ral director,	0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2 E	P/Outpatier	nt 3□ DO/	Othe	ar:				6 □Other (Sp	ecify)
	E	27. Manner of Death	28a. Date	of Injury 2	28b. Time of		c. Injury	at		d. Describe			ocay,
th. : After funer	亨	1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investi	19	th, Day Year)	Injury	М	Work	<br Yes 2 ☐ 1	No				
ial or Attanding s after death. al Director: After ed in by the fune	Certification:	3 Suicide 6 Could	not be 28e. Place	of Injury - At hon	ne, farm, str	eet, factory,	office		28				Rural Route Number,
after Dire	erti	4 Homicide	build	ing, etc. (Specity)						City or To	own, State	)	
To the Hospital or Atti within 24 hours after de To the Funeral Directo completely filled in by th		29a. Certifier 117 Certifyin	ng Physician: To the	e best of my know	dedge deat	h occurred a	t the tim	ne, date an	d place, an	d due to the	a cause(s)	and manner	as stated
Hos Pun Fun	edical		Examiner: On the b										
thin S the omple	Me	29b. Signature and title of certifie				29c.	License	number			29d. Dat	e signed (Moi	nth, Day, Year)
To To Con		NAT C	- 5	0		D	0894	44			Auc	just 19	. 2004
		- June	ovange	X 13									,
10	1	30. Name and address of person	who complete ca-	se of death (ttem:	23a) (Type.	Print)							
10			aı -	4 D	700 -						4	MD CCC	05 0330
			Shargel, I			arragu	t A	vaenu	e, Ke	nsing	ton,	MD 208	95-2110
	ate	Martin C. 31. Date filed (Month, Day, Year)	32. F	M.D. 3'		Apa			e, Ke	nsing	ton,	MD 208	95-2110

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 1:47P <sup>™</sup> Edith Bisgyer August 21, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 X F Yrs. Director 213-38-2070 86 1917 Russia Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Integrate: If item 27 is marked other than "natural", or items 23a or 28a-1 show many injury or other traumatic event, its Medical Evertainer must be rediffied at once. 28a-f show 1 ☐ Yes 2 XNo Director Maryland Montgomery Potomac 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9900 Glenolden Dr 20854 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Itel ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No þ Specify: If Yes, Give Year or Dates: Specify 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Bertram Marder <u>Sadie Unknown</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9900 Glenolden Dr. Potomac, MD 20854 Bert Bisgyer/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) King David Mem Gardens Aug 24, 2004 Falls Church, VA 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pnuemonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Congestive Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medicai attending f IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2√2 No 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and ptace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and ptace, and due to the cause(s) 29a. Certifier cai (Check only one) and manner stated within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 M.D. 20 D0027660 August 23, 2004 no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 11119 Rockville Pk, Rockville, MD 20852 Aldana Goswani, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 25 2004 Registrar

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1	Sta Registr

		State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Beg No. 2 (1.01)
		1. Decedent's Name (First, Middle, Lest)  2. Date of Death  3. Time of Death
-	Physician /Medical	Benny Lee Brooks AUGUST 19 2004 9:23 AM
7	Examiner	4e Fecility Name (If not institution, give street end number)  4b. City, Town, or Locetion of Deeth  4c. County of Death  CIVISTA MEDICAL CENTER  LAPLATA  CHARLES
	Funeral Director	5. Social Security Number 6. Sex 1 DXM 2 F 6. Sex 1 F 6. Sex 1 DXM 2 F 6.
	show dist	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	28e-1 shown citilled at	MD Charles Bel Alton ¹⅓Yes 2□No
	offer death with the Mei or items 23s or 28s-1 since must be notified Funeral Director	10e. Street end Number  10f. Zip Code  10g. Citizen of What Country?  U.S.A.
020	or S	3 □ Wildowed 4 □ Divorced Year or Dates:1060 □ 1062 □ 1□ Yes 2□ No Specify: Specify: Black
Maryland 21215-0020	led within 72 ho lygiene. her than "natura nt, the Medical E	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12) 7th  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fork Lift Operator  Safeway Foods, IN
land 2	tal H dod	18. Mother's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)
, Mary	s 1 end 2 should f Health end Mer tem 27 is marke other traumstic	19a. Informant's Name/Relationship (Type, Print)  Joyce A. Mitchell -Daughter 9912 Graystone Dr. Upper Marlboro, MD 207
Baltimore,	80= 510	20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State 4  Donation 5  Other (Specify)  20b. Place of Disposition (Name of cemetery, cremetory or other place)  Ft. Lincoln Cemetery 8/25/04 Brentwood, MD
Ball	Department Department Important any injury Drice.	21. Signature of Funeral Service Licensee  22. Name and Address of Facility 3821 14th ST, N.W. WDC 200  Austin koyster Funeral Home
	N. S. R.	23a. Part1. Enter lie disease, or complications that causing the distribution of the disease of the distribution of the distri
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. MULTIPLE MYELOMA  Due to (or as a consequence of):
	be executed cien end bunel-trensit	Sequentially list conditions.  Due to (or as a consequence of):
Box 68760,	ohysicie the bur	Cause (Disease or injury that initieted events Due to (or as a consequence of):
P.O. B		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death?
	gned by the deteche	DIABETES-TYPE 2 10 Yes 20 No 30 Probably 40 Unknown
Records,	aw requir	HYPERTENSION  24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?
a R	cete he	
of Vital	Physician: The this certificate ral director, peg. TO Be Co	25. Was case referred to medical examiner?  1
ion of	ng Phi ter thi neral	27. Manner of Death  1 Anatural 5 Pending 2 Accident investigation  28. Date of Injury (Month, Dey Year)  28b. Time of Injury Work?  1 Yes 2 No
Division	Patric Ti	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify)  28f. Location (Street and Number or Rural Route Number. City or Town, Stete)
	the Hospital hin 24 hours of the Funeral npletely filled	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.
	1241	29b. Signature and title of Pertifier  29c. License number  29d. Date signed (Month, Day, Year)  D-26064  29d. Date signed (Month, Day, Year)
	0	30. Name end address of person who completed cause of death (Item 23e) (Type, Print)  ANMANGANDLA VIDYASAGAR MD PO BOX 282 CHARLOTTE HALL MD 20622
	State	31. Date filed (Month, Day, Year)  32. Registrer's Signeture
211	Registrar	AUG 2 6 2004 Down & Sparker

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 19, 12:15 P M Butcher Ardrilla August 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park
If Under 1 Year | If Under 24 Hrs. Washington Adventist Hospital Montgomery 5. Social Security Number 8. Date of Birth Jan 23, 7. Age (In vrs. last birthday) 6. Sex Birthplece (State or Foreign
Country) **Funeral** Days 1□M 2፟EF Months Hours Min. 424-50-5350 65 Alabama Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show or than "natural", or items 23a or 28a-f shov The Medical Examinat must be notified at Director 1 ☐ Yes 2 No Prince George's Maryland Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7303 16th Place 20783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or health injury or other traumate. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black Yes, Give 'ear or Dates: 1 ☐ Yes 2 🖾 No þ Specify. 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry National Association Elementary/Secondary (0-12) College (1-4or 5+) Claim Examiner of Letter Carriers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elijah Shaw, Jr. Leada Bryant 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pania Yolanda Butcher/ Daughter 7307 16th Place, Hyattsville, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 24. 20c. Location - City or Town, State cometery, crematory
Rock Creek 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Washington, DC Cemetery 21. Signature of Funeral Service License Francis J. Collins Funeral Home Inc. University Blvd., W., Silver Spring, 500 MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only pnel cause og each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10WITVO /Medical Due (or as a consequence of) Examiner KINGROSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Examiner Due to (or as a consequence of) the attending physician and had for use as the burial-transit IPOR CTPI ent The resulting in death) Last Due to (or as a consequence of): Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown à Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ peq Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has autopsy perform certificate 1 🗆 Yes 2 DNo Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl. one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 **L**OOA 1 Inpatient 2 ER/Outpatient this After this 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending after death.

f Director: Aft
d in by the fun investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 12 30. Name and address of person who completed cause of (Item\_23a) (Type, Print) ID 1600 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **AUG 23** Registrar 2004

DHMH 17 Rev 1/2001

amend item#28b,d,T,perME, G842,4/6/05 III State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year August 23, Chery1 Revelle Bittner 2004 12:30pm<sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5649 Fort Ritchie Road Sabillasville Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Mar. 18. 1945 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1 M 2 XF 59 Yrs. Marvland 213-42-1790 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Sabillasville Director 1 ☐ Yes 2 XNo Frederick Md. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5649 Fort Ritchie Rd. 21780 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Personnel Director 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Calvin S. Burrier Sr. Margaret A. Bussard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James G. Bittner (Husband) 5649 Fort Ritchie Rd. Sabillasville,Md. 21780 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 26,04 Smithsburg, Md. Smithsburg Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Osborne Funeral Home 21. Signature of Funeral Service Licensee Mo1414 425 S. Conococheague St.Williamsport, Md. 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheet, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Insulin Shock Minutes Due to (or as a consequence of): Insulin Overdose Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Diabetes, uncontrolled Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Chronic Renal Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Chronic Anemia 1 ☐ Yes 2 ☐ No 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 X Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Unknjury 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 🛣 No 8/23/2004 12:30 M investigation 2 X Accident 6 Could not be determined 3 Suicide

physician and s the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ŏ the ģ page 2 certificate After

**Funeral** 

Director

or 28a-f show

, or Items 23a

natural

Hygiene.

and Mental Is marked of

permit. Pages 1 and 2: Department of Health ar Important: If item 27 Is any injury or other trau once.

Physician

/Medical

Examiner

other

the Medical Examiner must be notified at

the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: death. Director: 24 hours a e Funeral ( within 2 To the

5H-4 State Registrar

cal

29a. Certifier (Check only one) 29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

28d. Describe how injury occurred Subject took
Accidental Insulintoo much
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28f. Location (Street and Number or Burai Rolling)

28f. Location (Street and Number or Burai Rolling)

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Rd. Sabillasville, MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

> D35164 August 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Zarick, Jr, MD, 15 West Seventh Street, Frederick, Maryland 21701-4501 32

31. Date filed (Mon AUG 30 2004

4 - Homicide

egistrar's Signature

			State of Maryland / Department of Health and Mental Hygiene								
		1	1 - For State Registrar Certificate of Death Reg. No. 1 1 2 2 2 5	20							
		_	1. Decedent's Name (First, Middle, Last)  2. Date of Death  North (Day Year)	Death							
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	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death								
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b	e filed of her vent,	Se C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)								
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			MD D0056449 3/24/04								
	6 d VA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \							
`	y *		Gloria Simonson MD III West High St. Dute Dd Elkton MD 170	7							
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Division	of Vital	Division of Vital Records, P.O. Box 68760,
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	1	For State Registrar			rtificate of		, ,	g. No. )	00000
Physician /Medical		1. Decedent's Name (First, Middle, Andrew	Last) Thomas	Bucl	kler		2. Date of Death Month August	Day Year	7:30PM M
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h with the Ma 23a or 28a-f s 1st be notified		10e. Street and Number 6510 Pepin Di	rive		10f. Zip Code 20772		10	g. Citizen of What C	
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and 2 sho ealth and I m 27 le me ser traums		19a. Informant's Name/Relationship Ray Buckler (SC	) (Type, Print) )N)					City or Town, State, Maryland	
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it. Partmen	-	<ul> <li>4 □ Donation 5 □ Other (Spe</li> <li>21. Signature of Funeral Service Lic</li> </ul>		Maryland	Veterans	Cemetery	C Funeral	heltenham Home, Inc	, Maryland
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-9%		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause	d the death. Do not en	ter the mode of dyin	ng, such as cardiac o	or respiratory arre	st,	Approximate Interval Between
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rsicien: The law s certificate has t lirector, page 2 s							autopsy perform 1 Yes 2	egt?   death?	completion of cause of
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nP5+1				death (Item 23a) (Type, O Old Line		207 Wa <b>1</b> doı	rf, Marvi	land 20602	2
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 25,2004 Year **Physician** Mary 9:30PM Allelin Blankenship /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Civista Hospital LaPlata Charles 8. Date of Birth (Month, Day, Year) June 3,1930 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Washington, DC 5. Social Security Number 6 Sex **Funeral** Months Min Days Hours 1 ☐ M 2 ☐ XF Yrs. Director 215-26-3133 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits en "neturet", or Items 23a or 28a-f show Medical Examinar must be notified at 1 Yes 2 No Funeral Directo Maryland Prince George's Brandywine 10e. Street and Number 10g. Citizen of What Country? 10505 Cedarville Road Lot 716 20613 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a any jnjury or other freumatic event, the Medical Examiner mass 200.00. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. White 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltifhore, Maryland 21215-0036 Specify: Specify þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Roxie (Unknown) Claude Richardson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5430 Coveview Drive St. Leonard, Maryland20685 19a. Informant's Name/Relationship (Type, Print) James Wright 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 30. 1 □ Burial 2 □ Cremation 3 □ Removal from State Suitland, Maryland Cedar Hill Cemetery 2004 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licensee m00257 6633 Old Alexandria Ferry Road Clinton, MD20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burial-Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 I ive birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 4 Unknown 1 Tyes 2 No Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? 2[] No 1 ☐ Yes 2 No 1 Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 2 3 DOA 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending 1 Natural death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident after death completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funerel L 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Wisotsky, M.D. 12070 Old Line Centre # 207 Waldorf, Maryland 20602

State Registrar 31. Date filed (Month

istrar's Signature

3 0 2004

		4	For State Registrar	State of Marylar				ealth and Death	Mental H	ygien Reg. <b>N</b>		28635
/N	/sicia	ai	1. Decedent's Name (First, Middle, La Lucille Hazel Bo	nd		4. 05	T	1	2. Date of the Month August	r 27		3. Time of Death 12:00p <sup>M</sup>
Fune		-1		Road Sex 7. Age (In yrs.		Cli	nton r 1 Year	If Under 24 Hi Hours Min	S. 8. Date of E	Birth	c. County of Death rince Geo  9. Birthp County 10020	orges place (State or Foreign shington, D
Direc			216–12–4062 Usuel Residence of Decedent 10a. State 10b. County	8	4 Yrs. ty, Town or Lo	ocation			Februar	rý 3,		0d. Inside City Limits
with the Ma	De notiffice	Directo	10e. Street and Number	e Georges	Clinto	-	p Code	20735		10g. C	itizen of What Cour	1 □Yes 2 No
d 21215-UU36 filed within 72 hours after deeth with the Maryland Hygiene. ther than "natural", or ttema 23a or 28a-f show	MATTER CHAI	by Funeral	2209 Floral P  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 2 No II Yes, Give Year or Dates:	1	Was Dece If Yes, sp			(Specify Yes or I	No-	14. Race - Americ Black, White,	
21215-0036 d within 72 hours af giene. er then "natural", or	The Medical B	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)			kind of w DO NOT	ual Occupa ork done d use retired	luring most of w )	orking		Kind of Business/Inc	dustry
da b	9	To Be C	17. Father's Name (First, Middle, Las Julian F. Johns	on				Ida	ame (First, Midd Madeline	e Mad	ldox	
C = M	othar traumatic		19a. Informant's Name/Relationship  David W. Bond /  20a. Method of Disposition	Son		Flo	al P	ark Roa	d; Clint	con,	or Town, State, Zip MD 20735  .ocation - City or To	5
Baltimore, permit. Pages 1 a Department of Hea Important: if item			1 🔀 Burial 2 Cremation 3 [ '4 Donation 5 Other (Speci	ify) Mo	unt Re	st Ce 2. Name a	emete nd Addres	ry Sep	Williams	Fun	LaPlata, meral Home Mead, MD	
8 760, ate be executed Wedi Exami hysician and	ical ner	I Examiner	23a. Part1. Enter the dipease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Dicate of 1987) that initiated events resulting in death) Last	nplications that caused the deal	quence of):		de of dying					Approximate Interval Between Onset and Death
death certific death certific e attending p	ched for use as the t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 Live birth 2 Fete 4 Pregnant at time of c	al death 3 🗌	]Ectopic (	pregnancy				23d. Date of delive Month	ry Day Year
r r	pe q	<u>ک</u>	Part II. Other significant conditions continuing to beautiful for less uning in the underlying cause given in rait.							tobacco use contribute to the cause of death?  Yes 2/100 3 Probably 4 Unknown		
	page 2	Completed								opsy formed?	prior to cor death?	osy findings available inpletion of cause of
n of ng Phys tter this	nera	ertification; To Be	25. Was case referred to medical examiner?  1 Yes No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work	r: 4 🗆 Nursing		nnly one)  Residence 6 Other (Specify)  ribe how injury occurred		*)
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte	lled in by the	O	3 Suicide 6 Could not 4 Homicide determined	building, etc. (Speci	fy)				City or T	own, Stat		
the Hosp thin 24 ho the Fune	mpletely fi	Medical		hysician: To the best of my knominer: On the basis of examination and manner stated.		vestigatio		inion, death oc		e, date an		the cause(s)
To To	8	_	30. Name and address of person who	completed cause of death (Ite.	m 23a) (Tuno		~	4536.	5		8-30-04	
MP20	Sta gistr		31. Date filed (Month, Day, Year)  AUG 3 0	1) # 1 1 1 32. Reg strar's Sign	1 ft	WA	sh-	,ta	MD	20	744	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Adg 1 22 2004 **Physician** Dorothy Broach 1925 P <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Examiner Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 8. Date of Birth Johnson, Day Year 921 9. Birtholace (State or Foreign Days 1 □ M 2 □ X 074 14 7479 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Exer. it at must be notified at Prince Frederick Calvert Maryland 1 Tyes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20678 2785 Adelina Road death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White etc. White 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than \*r any fulury or other traumatic event. If \*\* Mexital Bank Bank Bank Bank Bank Bank Bank Elementary/Secondary (0-12) College (1-4or 5+) own home 12 homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Denis F. Browne Mary Tiernan ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2785 Adelina Rd. Prince Frederick MD 20678 John Broach— son 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug 26 200 Metropolitan Funeral services 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Alexandria Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final vasculocollesse **Physician** (ardro disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the Enter Inderlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown as been signed by to 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 1 No 1 Yes 2 No 1 TYes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 🛣 No 1 Manatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funeral D tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) My D 23468 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kushner, M.D. Prince FRederick Maryland 20678 31. Date filed (Month, Day, Year) 32. Registras Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deam Month Day Year **Physician** Virginia 0. Berthy 22, 9:55 a<sup>M</sup> August 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Collington Nursing Home Mitchellville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🖾 F Months Hours 234-28-8792 88 **Director** March 31, 1916 West Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or Hems 23 cor 28e-f ehow ant: If item 27 is marked other then "naturel", or Hems 23 cor 28e-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is marked other then "naturel", or Items 23s or 28e-f ehow reumstic event. Its Medical Examinar must be notified at Maryland Prince George's Mitchellville 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10450 Lottsford Road 20721 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. ☐ Yes 2 ☑ No Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary NEA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard Berthy Kate Hyer ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sue Ella Meadows-Cousin 27685 Villa Road, Easton, Maryland 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö permit. Page Department of Importent: If eny injury or once. Metropolitan Crematory |08/25/2004 | Alexandria, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gasch's Funeral Home, P.A. laudatte 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6per (1 **Physician** dev disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 4 LCARVES 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate I 1 Tes 2 No To the Hospital or Attending Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 TDOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D25079 August 23, 2004 se of death (Item 23a) (Type, Print) Don H. Yablonowitz, M.D. 7404 Executive Place #502, Lanham, Maryland 20706

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 2 7 2004

porte

Registrar's Signature

		1	For State Registrar	State of Ma	ıryland / Depa <i>Cei</i>	artment of F tificate of			Reg. No. 0 0 0 0 0		
	Physicia	in	Decedent's Name (First, Middle, Las  LOIS	ANNE	CARROL	r		2. Date of Death Month AUG -		ear 04 5:30 P M	
	/Medic Examin		4a. Facility Name (If not institution, give		CARROL		or Location of Death	AUG.	4c. County of		
			MARINER HEALT			_	LAUREL		1	GEORGES	
	Funeral Director		5. Social Security Number 6. Se 11	ax 7.Age □M 2 <b>)</b> TF	(In yrs. last birthday)  76  Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV . 4,	Year) 9	Birthplace (State or Foreign Country)  WASH. D.C.	
3		}	Usual Residence of Decedent					NOV. 45	1721		
	28a-f ehow	ō	10a. State 10b. County	PEODOEC	10c. City, Town or Lo		UREL			10d. Inside City Limits  YOYes 2 No	
1	7.28a-f	rect	MD - PRINCE (	EORGES		10f. Zip Code	UKEL	10	g. Citizen of Wha	at Country?	
1	23a o	aiD	1101 WHITE V	IAY			20707		U.S	.A.	
36	permit. Fages 1 and 2 should be liled within 72 hours siter deeth with the maryland Department of Health and Mential Hygiene. Department of Health and Mential Hygiene. Important: if them 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, it a Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ▼Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 W If Yes, Give Year or Dates:	lo	Was Decedent of Interpretation	tispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. WHITE	
5-0036	atura ical E		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation during most of work	ring 1	6b. Kind of Busir		
121	han "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retire	(d)	ang	нав		
d 21	Hygie Hygie other t		17. Father's Name (First, Middle, Last)	4	EX	ECUTIVE :	18. Mother's Name	e (First, Middle, M	U.S.D.	Α.	
Maryland	Mental Mental arked c	To Be	RAYMOND	CORRIDON				ANNIE	CHAN	EY	
Mary	h and h and 7 le mu		19a. Informant's Name/Relationship (7 ANNIE LAURIE CA	Type, Print) GRAN	D 19b. Mailir	,	and Number or Run				
<u>ق</u> .	Heali Heali Item 2		20a. Method of Disposition		20b. Place of Dispo					ty or Town, State	
imo	rage nent o ant: If ury or		1 Ma Burial 2 □ Cremation 3 □  `4 □ Donation 5 □ Other (Specify			CEMETERY		-2004 1	BURTONSV	ILLE, MD.	
Baltimore,	Departi Departi Importi any inj		21. Signature of Funeral Service Licen	there fill	C	P. Name and Address 1801 CLEV	ess of Facility FUNERAL HO ELAND AVE	OME & CRI	EMATORIU DALE, MD	M,P.A. 20737	
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that caused one cause on each lir	the death. Do not ent ne.	er the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death	
	nysician /Medical	9	Immediate Cause (Final disease or condition resulting in death)	a	CELL CANCE a consequence of):	R					
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	ricate be executed physicien and is the burial-transit	that initiated events resulting in death) Last Due to (or as a consequence of):									
68760,	ysicien	edicai		. d							
	death certi e attending ed for use a										
		Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	y		23d. Date of Month	·			
α.	equires that the de sen signed by the a rould be detached t	y Phy	Part II. Other significant conditions c	ontributing to death b	ut not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did toba	acco use contribu	ute to the cause of death?	
rds	w requires been sign should be	ed by						1 🗀 Ye	s 2 <b>X</b> No 3	□ Probably 4 □Unknown	
of Vital Records,	e law i has be	Completed						24a. Was an autopsy perform	ed? prio	re autopsy findings available or to completion of cause of the cause o	
Vita	Pnysician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0*	hor	h (Check only one			
	ng Pnys fter this ineral di	tion: To	1 ☐ Yes 2 ★ No  27. Manner of Death  1 ★ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	nt 2 ER/Outpatier ry 28b. Time o lnjury	f 28c. Inju	4 Nursing Hu	ome 5 Resider 28d. Describe how			
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	-	ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (Str. City or Town,		or Rural Route Number,	
	ne Hospil n 24 hour ne Funera netely fille	edical (			of my knowledge, deat examination and/or in ated.						
	To the comp	W	29b. Signature and title of certifier	1110		29c. Licen	se number	29	d. Date signed (/	Month, Day, Year)	
	. N		damp	He			053235		AUG.	19, 2004	
	10		30. Name and address of person who  DARRYL A. HILI		eath (Item 23a) (Type, 13635 BALT		E.,LAURET	, MD. 207	707		
	Sta Registi		31. Date filed (Month, Day, Year)  AIIG 2.3 201	32. Registr	ar's Signature	books					

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar		artment of H		nd Mental Hy	giene	101	0.5.2.0.0
	Physicia /Medic Examin	an al	1. Decedent's Name (First, Middle, Last)  Onway Lee  4a, Facility Name (If not institution, give s	Carter J		4b. City, Town, or Tako	Location of	2. Date of De Month	Day	Year ZOUY unty of Death	3. Time of Death
	Funeral Director		Washington Advent.  5. Social Security Number 217–14–3312		last birthday)	If Under 1 Year Months Days	If Under 24			9. Birth	ery  place (State or Foreign  intry)
	within 72 hours after death with the Maryland ane. then "netural", or tems 23a or 28e-f ehow he Medical Examinar must be notified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G		ty, Town or Lo lelphi				10a Citizon	of What Cou	10d. Inside City Limits 1 ☐ Yes 2 X No
	death with I ms 23a or 2 must be n	neral Dir	10e. Street and Number 8713 23rd Court 11. Marital Status	12. Was Decedent Ever in U	.S. 13.	10f. Zip Code 207 Was Decedent of Hi		n? (Specify Yes or No Puerto Rican, etc.)	Unit	ed Sta	ican Indian,
9000	hours after tural', or Ite	d by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1X Yes 2 No If Yes, Give Year or Dates:1943—	1945	1 Yes 2 No 1 Yes 2 No dent's Usual Occupa	Specify:	Puerto Rican, etc.)	Spi	ecity: White	nite
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene if Health and Mental Hygiene items 23a or 28e-f ehow item 27 is marked other then "natural", or Items 23a or 28e-f ehow other traumatic event, The Medical Examinar must be notified at	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life.	kind of work done of DO NOT use retired Employed	during most o		Custo	om Home	e Building
Maryland	should be file nd Mental Hy marked oth umatic event	To Be (	17. Father's Name (First, Middle, Last) Conway Lee Carter  19a. Informant's Name/Relationship (Ty,	ne Print)	19h Maili	ng Address (Street	Mary	S Name (First, Middle Gladys Je	tt		in Code)
ď.	es 1 and 2 shu of Health and If item 27 Is m ar other traum		Annie C. Carter, w  20a. Method of Disposition 1 Burial 2X Cremation 3 B	ife 20h F	Place of Disno	nsition (Name of	T	or Rural Route Numbel phi, Mar	20c Locati	ion - City or T	
Baltimore,	permit. Pages 'Department of H Importent: If ite any injury or ot		4 □ Donation 5 □ Other (Specify) 21. Signature Fuveral Service Libens				i				A. vland 20705
760,	ate be executed // Medical // Medical sud // Medical // Proposition and // Proposition // Propos	Ical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If you have the cause in the cause in the cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)				Approximate Interval Between Onset and Death			
.O. Box 68	death certific e attending pl d for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>			23d.	. Date of deliv	very Day Year		
S, D	sign d be	þ	Part II. Other significant conditions cor		Did tobacco use contribute to the cause of death?						
of Vital Record		Completed	Subcutaneous Lung Cancer	emphyse	MA			24a. Was auto perfe 1 Yes	opsy prior to completion of cause of death?		
ion of Vita	ttending Physicien: The death. ctor: After this certificate y the funeral director, pag	atlon; To Be	25. Was case referred to medical examiner?  1 Yes 2 No Figure 1  27. Manner of Death  1 Natural 5 Pending investigation	lospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatie 28b. Time o Injury	f 28c. Injury Work	er: 4 ☐ Nurs	f Death (Check only ing Home 5 ☐ Res 28d. Describe	idence 6 🗆		ify)
Division		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		reet, factory, office		28f. Location ( City or To	Street and Ni wn, State)	umber or Rur	ral Route Number,
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in b	Medical	(Check only 2 Medical Exami	sicien: To the best of my knoner: On the basis of examination and manner stated.	owledge, deat ation and/or in	th occurred at the tin evestigation, in my of	red at the time, date and place, and due to the cause ion, in my opinion, death occurred at the time, date a			ice, and due t	to the cause(s)
	á	-	29b. Signature and title of confile	Sent	>	Do	0533	537		gned (Month,	
	, b 		30. Name and address of person who con Dorothy Seay, M.D.	10801 Lockwo	ood Dri		Silve	r Spring,	Maryla	and 209	901
	Sta Registi		31. Date filed (Month, Day, Year)  AUG 27 200	32. Registrar's Sign.	# 1	Sparks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** AUG. R. CARTER, Jr 22, WENDELL 3:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7510 Old Muirkirk Road Beltsville PRINCE GEORGES 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours 218-36-6617 1**⊠**M 2□F Yrs. Director Maryland Jan. 18, 1940 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "neturel", or Items 23e or 28a-f shov other treumetic event. It is Marked Examiliar I was be inclined at 1 TWes 2 □ No Director Prince Georges Beltsville MD10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with 7510 Old Muirkirk Road 20705 U.S.A. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after all Hygiene "neturel", or Itel 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: ģ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) International Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Paper Company 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fi and Mental H Wendell R. Carter Sr. Grace Snowden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh
Department of Health and
Importent: If item 27 is m
any injury or other treum Barbara C. Carter- Wife 7510 Old Muirkirk Rd Beltsville, MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/27/2004 Beltsville, MD \* 4 ☐ Denation 5 ☐ Other (Specify) Queen's Chapel Cem' 22. Name and Address of Facility Snowden Funeral Home gnature of Funeral Service Licensee 246 N Washington St Rockville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRAIN CANCER / ASTROCYTOMA Pnysician lyear disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner STROKE 6 Months Sequentially list conditions, any, course to instructions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transil DIABETES, HYPERTENSION that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown by signed b Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death Check onl one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 1 ☐ Yes 2 🔀 No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by i 4 | Homicide within 24 hours a 29a. Certifier XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai

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Baltimore, Maryland 21215-0036

Box 68760

P.O. P

Division of Vital Records,

Registrar

Dr. Nadu Tuakli, 31. Date filed (Month, Day, Year)

2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

MA

10814 Hicory Ridge Rd, Columbia, MD

make

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D38183

29d. Date signed (Month, Day, Year)

AUG 26 DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

		State of Maryland / Department Certifica	it of Health and Mental Hy te <i>of Death</i>	ygiene						
	Physician	1. Decedent's Name (First, Middle, Last)	2. Dete of D Month	Dev Year						
-	Pnysician /Medical	MILLIAM CHIDERE	08	19 2004 2035						
	Examiner		4b. City, Town, or Location of Dee							
	e_	RUXTON HEALTH CENTER  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	DENTON r 1 Year   If Under 24 Hrs.   8, Date of B	irth 9 Birthologo (State or Foreign						
	Funeral Director		Days Hours Min. (Month, D SEPT 2	9. Birthplace (State or Foreign Country) 1, 1923 LITHUANIA						
	show the strong show	10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits						
	the Maryle 28a-f sho norified at	MARYLAND CAROLINE DENTON  10e. Street end Number 10f. Zi		1 X Yes 2 No						
	3a or	420 COLONIAL DRIVE	o Code 629	10g. Citizen of Whet Country?  UNITED STATES						
0	72 hours after death with the Marylend natural; or items 23s or 25s-f show likel Examiner must be notified at effect by Furneral Director		dent of Hispanic Origin? (Specify Yes or N cify Cuben, Mexican, Puerto Rican, etc.)							
21215-0020	led within 72 hours a ygiene. Yer than "natural", o rt, the Medical Exar Completed by	3 ▼ Widowed 4 □ Divorced If Yes, Give Year or Dates: WWII	2X No Specify:	Specify: WHITE						
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שַ	tal Hygi d other event,	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	e, Maiden Sumame)						
Maryland	permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Itam 27 is marked othe any injury or other traumatic event, DDCs.	MAX CHIDEKEL	LEAH	'UNKNOWN'						
lan	2 sho and is me	19a. Informant's Neme/Reletionship (Type, Print)  19b. Mailing Addres	s (Street and Number or Rural Route Number							
	l and tealth m 27 her tr		WICK DRIVE, HIGHLAN							
Baltimore,	permit. Pages 1 and Deportment of Health Important: If Itam 27 any Injury or other to once the once th	1 Burial 2 Cremation 3 Removel from State	other place)	20c. Location - City or Town, State						
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Ва	permi Deper Impor any in	Janus 1091 I	O SACEL FÜNERAL DIRE ROCKVILLE PIKE, ROCK	VILLE, MD 20852						
3,000	Physician	23a. Part   Enter the disease, or complications that caused the death. Do not enter the modeshoods, or heart failure. List only one cause on each line.	de of dying, such as cardiac or respiratory a	arrest, Approximate Interval Between Onset and Death						
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. SEPTICEWIA	<b>S</b>	HOURS						
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	ficate be executed the physician and state buriel-trensit set the buriel-trensit edical Examiner	b. URINARY TRA	ter INFECTION	ADA9						
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39 X	certifice certifice nating plus as a start when when we have a start when we have a start with the contribution of the contrib									
Вох	death death deore	Part II. Other significant conditions contributing to death but not resulting in the underlying	purpo circon in Port I 22h Did	tobacco use contribute to the cause of death?						
P.0	es that the death cert igned by the attending be detached for use. by Physician/M	Control significant containing to death but not resulting in the underlying to		Yes 2 No 3 Probably 4 Unknown						
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<u>}</u>	hysic his ce al dire	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DO		idence 6 ☐Other (Specify)						
ם ט	Ing P	27. Me/ner of Death 1. Naturel 5 □ Pending   28a. Date of Injury (Month, Dey Year)   28b. Time of Injury   28	Work?	how injury occurred						
isio	death death tor: / tha f	2 Accident investigation M 3 Suicide 6 Could not be determined could not be determined	1 ☐ Yes 2 ☐ No	(Street and Number or Rural Route Number,						
Division of Vital	ertif	4 Homicide determined determined building, etc. (Specify)		wn, State)						
_	To the hospital or Attending Physician: The law within 24 hours efter death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: Medical Certification: To Be Compl	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred examination and/or investigation and manner stated.	at the time, date and place, and due to the , in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)						
	ithin omple		c. License number	29d. Date signed (Month, Day, Year)						
	- 5 - 0	Jan Mar 22 DIEteror	D0053094	8-20-2004						
	5	30. Name end address of prison who completed cause of death (Item 23e) (Type, Print)								
		Paul Rhienbold, MD 420 Colonial D	rive, Denton, Ma	ryland 21629						
3k	State	31. Date filed (Month, Day, Year) 32. Registrer's Signature	oaks							
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.) 2. Date of Death 3. Time of Death -1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** рм August 17, 2004 8:30 Phuong Dat Chung /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 24, 1943 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Min. Months Hours 1፟፟፟፟ M 2□F Vietnam 60 580-18-3209 Director Usuat Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. Count ed other than "neturel", or Items 23a or 28e-f show event, the Madical Exercit at Inust be notified at 1 ☐ Yes 2 ☑ No Silver Spring Maryland Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20902 USA 702 Kenbrook Drive death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No tf Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: Asian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: by 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Restaurant Chef Health and Mental Hygie tem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Hao Luong Chung 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages .
Department of Health Importent: If item 27 any injury or other 702 Kenbrook Drive, Silver Spring, MD 20902 Muoi Chung/ Wife 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Gate of Heaven August 25, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 2004 Cemetery
22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
Francis J. Rlyd. .W., Silver Spr 21. Signature Pineral Service Licensee 500 University Blvd., W., Silver Spring, MD 20901 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest a cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final Acute Gastric Bleeding Less than Physician disease or condition Day /Medical resulting in death) Due to (or as a consequence of): **Examiner** Metastatic Hepatocellular Cancer 1 Year Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day õ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate To the Hospitel or Attending Physicien: in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 录No Medical Certification: To this 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation death. after death 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a npletely filled 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number tte of certifier 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 80 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 23 State 2004

DHMH 17 Rev 1/200

Registrar

Rence

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 19, 2004 5:11 P M COHN JOSEPH D. /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S LAUREL. LAUREL REGIONAL HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, MAR 7, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Hours 1₩ 2□F PENNSYLVANTA 84 155-01-6090 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28a-f show or items 23s or 28s-f show 1 Yes 2 No Director MONTGOMERY MARYLAND SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3160 GRACEFIELD ROAD UNITED STATES 20904 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status the Medical Examiner: 1 ☐ Never Married 2X Married 1 XI Yes 2 □ No 1942— If Yes, Give Year or Dates: 1945 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify. 2 3 ☐ Widowed 4 ☐ Divorced 1945 WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANAGEMENT ANALYST FEDERAL GOVERNMENT 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Int: If item 27 is marked o HERMAN COHN BESSIE WEISBERG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19108 HARKNESS LANE, GAITEHRSBURG, MD 20879 HENRY A. COHN, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 X Removal from State NATIONAL CREMATORY 8/23/2004 FALLS CHURCH, VA \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 21 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HEPATIC ENCEPHALOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEPSIS 1 ☐ Yes 2 🕱No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has ACUTE RENAL FAILURE autopsy 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 X No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: Fe the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi 29c. License number pleted cause of death (Item 23a) (Type, Print) 15 loge fK 20740 WARA Kechi OI Gree 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **AUG 24** Registrar 2004

DHMH 17 Rev 1/2001

**ORIGINAL** 

			For State Registrar	State of	f Maryland		irtment of H tificate of L		nd Me	, ,	D (D)		
			Registrar     Decedent's Name (First, Middle, Last)				incate of L	Jeann	2	Reg. Date of Death	No.	S. Time of Déath	
	Physicia				dward CO	OLEN.				Month ugust 21	Day 2004	5:00 A	И
	/Medic Examin		4a. Facility Name (If not institution, give			JEEN	4b. City, Town, or	Location of		ugust Zi	4c. County of		
	Examin	er	Suburban Hospital		•		Bethes	sda			Montg	omery	
	Funeral		5. Social Security Number 6. Sex		7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24	4 Hrs. 8 Min.	. Date of Birth (Month, Day, Ye	ear) 9.	Birthplace (State or Foreig Country)	רון
	Director		212 00 0003	]M 2□F	48	Yrs.	Monaio Dayo					Washington,	
	and w	-	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limit	s
	daryl f sho	ō	Maryland Montgome	rv		Poto	mac					1 ☐ Yes 2 📉 No	0
	the t	Director	10e. Street and Number	<u>y</u>			10f. Zip Code			10g.	. Citizen of Wha	at Country?	_
	h with		11824 Seven Locks	Road			2	20854			United	States	
	d within 72 hours after death with the Maryland Jene. I then "naturel", or Items 23s or 28s-f show The Madical Examiner must be natified at	Funeral	11. Marital Status	12. Was Dece Armed Fo	ident Ever in U.S	. 13. \	Vas Decedent of Hi Yes, specify Cuba	spanic Origi	in? (Specif	fy Yes or No-		American Indian, White, etc.	
9	or It		1 Never Married 2 ☐ Married	1 ☐ Yes If Yes, Giv	.2 ₹ No		☐Yes 2√2 No	Specify:		,,	Specify:	white	
8	hours urel',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Da	ates:		ent's Usual Occupa	ation		101	o. Kind of Busin		
7	n 72 i "nat	Completed	15. Decedent's Edu (Specify only highest grade	ompleted)		(Give	kind of work done of NDT use retired	during most o	of working	101	o. King of Busin	less/industry	
7	I within jene.	шо	Elementary/Secondary (0-12)	College (1	-4or 5+)	no	ne				none		
b	otha vent,	a	17. Father's Name (First, Middle, Last)					18. Mother	's Name (/	First, Middle, Mai			
<u>a</u>	should be nd Mental markad o	To B	Ralph Colen						Sonia	a Moreno			
Maryland 21215-0036	2 sho and l is me		19a. Informant's Name/Relationship (Ty				g Address (Street a				-		
3,	and ealth m 27 har tr	11	Sylvia Berman, Sis	ter	20h Bio		Wild Oliv sition (Name of	re Dri	ve, I			854	
O	or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	temoval from	State cer	metery, cren	natory or other plac				. Location - Gir	y or Town, State	
Baltimore,	t. Pa ntmen rtent: njury		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funera Service Licens		Mt.		on Cemete . Name and Addres			/04 A	delphi,	MD	_
Ba	permit. Pages 1 and 2 should be Department of Health and Ments Importent: If item 27 is marked any injury or other treumstic a once.		21. Signature of Funetal Service Licens				rchinsky			neral Ho	me		
	_		23a. Part Fenter the disease, or compl	ications that co	aused the death.	Do not ent	4 Carroll or the mode of dying	g, such as ca	ardiac of r	Washing espiratory arrest,	ton, DC	20012 proximate	
	Discontinuo.		shock, or heart failure. List only of Immediate Cause (Final	ne cause on e	ach line.		mis					Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	1 Due to (	or as a conseque		July						
	Examiner		Cognentially list conditions	2									
	P #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a conseque	ence of):							
	ecute and -trans	Examine	that initiated events resulting in death) Last	Due to (	or as a conseque	ence of):							
8760,	The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	alE											
687	ficate p phys is the	d											
Вох	eath certifi attending ( I for use as	M/U	fF FEMALE: 23b. Was decedent pregnant		come of pregnan		)				23d. Date of	f delivery	
	death e atte	Physician/M	In the past 12 months?  I gray a contract of the past 12 months.  I gray a contract of the past 12 months.  I gray a contract of the past 12 months.  I gray a contract of the past 12 months.  I gray							Mon		h Day Year	
P.0	at the de by the a stached	hys	9 □ Unknown										
	res tha igned be de	by	Part If. Other significant conditions con		Sath but not result	/ 1		en in Part I.				te to the cause of death?  Probably Junknowi	n
Records,	v require been si	Completed	Joeco 1	3 4	3910	161	n e			-			_
Sec	e law has b	nple								24a. Was an autopsy performec	prior	e autopsy findings available r to completion of cause of th?	8
alF										1 Yes		Yes 2□ No	
Vital	Physician: this certific ral director.	o Be	25. Was case referred to medical examiner?	lospital:	npatient 2 E	'D'(O-14-14)	t 3 DOA Othe	ar		Check only one)	- 0 DOth/	0	
of		<b>-</b>	1 Yes 2 No	28a. Date	of Injury 2	R/Outpatien 28b. Time of	28c. Injury	at at		5 Residence d. Describe how i		<i>эрөспу)</i>	_
ion	nding fith. : After a funer	atlor	Natural 5 Pending investigation	(Mont	th, Day Year)	Injury	M 1 🗆 '	Yes 2 □N	0				
Division	Attendi er death. ector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	of Injury - At hon	ne, farm, str	eet, factory, office		281	Location (Stree City or Town, S		or Rural Route Number,	
	itel or rs after el Dir led in	Cer											
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	ner: On the ba	asis of examination	rledge, death on and/or in	occurred at the time vestigation, in my op	ne, date and pinion, death	place, and occurred	d due to the caus at the time, date	e(s) and manne and place, and	er as stated. due to the cause(s)	
	thin 2 thin 2 the	Med	one) 29b. Signature and title of certifier	and man	ner stated.		29c. License	e number		29d.	Date signed (A	fonth, Day, Year)	
	7 × 7 8		Maria no	1/1/	011.	700		23/3	2		8.21.	1	
,	3		30. Name and address of person who co	mpleted caus	e of death (Item:	23a) (Type		< 3/	10		0 411	_ /	
			Gita C. Bakshi, 1					., Bet	hesda	a, MD 2	0814		
	Sta	ate	31. Date filed (Month, Day, Year)	32. R	egistrar's Signatu		1						
	Regist	rar	AUG 24 20	JU4	a part	10	Spark.	2/					

		1	For State Registrer	State	of Maryla		artment of H tificate of		l Mental Hy		i y y y y y y pro
			Decedent's Name (First, Mid-	dle, Last)	-		imouto or		2. Date of De		3. Time of Death
	nysicia		HAR	RIET BEI	ECHER	CROSTO	N		AUG.	24, 2	Year 004 8:55 P M
	Medic xamin		4a. Facility Name (If not instituti				4b. City, Town, o	or Location of De	ath	4c. County	
			CIVISTA H	OSPITAL			]	LAPLATA			ARLES
	neral		5. Social Security Number	6. Sex 1 ☐ M 2 <b>X</b> F		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of Bir (Month, Da	th ay, Year) 9, 1924	Birthplace (State or Foreign Country)
	ector	-	343-16-0671 Usual Residence of Decedent		80				FEB. Z	9, 1924	NEBRÁSKA
yland	描		10a. State 10b. Coun	ty	10c. 0	City, Town or Lo	cation				10d. Inside City Limits
the Marylar	E PA	ctor	MD. CHAR	LES			WALI	OORF			1 XYes 2 □ No
ith the	No.	Oire	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Country?
ath w		- La		SDEN CT.				0602		· · · · · · · · · · · · · · · · · · ·	S.A.
11215-0036 within 72 hours after death with the Maryland ene.	itan £1 is marked cities user instities, or remisized of zoon sind other treumetic event, it is Mcdical Examiner must be mutified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marital Additional  Armed 1 Tyes	ecedent Ever in Forces? s 2 No Give	1	Mas Decedent of F f Yes, specify Cub I ☐ Yes 2 XNo	an, Mexican, Pu-	(Specify Yes or No erto Rican, etc.)		- American Indian, K. White, etc.	
215-0036 thin 72 hours aff	al Ex	ed b	3 ☐ Widowed 4 🛣 Divorce	ent's Education	Dates:	16a, Dece	lent's Usual Occur	pation		16b. Kind of Bu	BLACK siness/Industry
15.	Asdic	plet	(Specify only high Elementary/Secondary (0-12)	nest grade complete	d) (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of w	vorking		HOSPITAL
212 od with giene	T B	Completed	12	College	(1-40/5+)		CLEI	RK		ST. EL	IZABETH'S
Maryland 2121	evant	Be	17. Father's Name (First, Middle						lame (First, Middle		a)
Maryland d 2 should be file th and Mental Hy	netic netic	2		ERICK	EAST		- Address /Ctrast	1	PEARL	LEAK	State 7in Code)
Mar d2st th and	treun		19a. Informant's Name/Relation  RICARDA D. EA		P NTECE	4352			Rural Route Numb		
ore, M	othar	-	20a. Method of Disposition	SIUN/ GREA.		Place of Dispo	sition (Name of		Date		Zity or Town, State
0 0 0	طع		1 ☐ Burial 2 XCremation 3 4 ☐ Donation 5 ☐ Other				natory or other pla	- I	6-2004	RTVERD	ALE, MD.
Baltimore,	any injury or one		21. Signature of Funeral Service			22	. Name and Addre	ss of Facility			
<b>a</b> § §	E S S		> 21/21/- C	pambe	MO	0091 5	BOL CLEVI	UNEKAL ELAND AV	HOME & CI	REMATURI RDALE, M	DM, P.A. D. 20737
Pnys	ician		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition	st only one cause or	it caused the de n each line. BETES MI		er the mode of dyi	ng, such as card	iac or respiratory a	rrest,	Approximate Interval Between Onset and Death
/Me	dical		resulting in death)	и.	to (or as a conse						
Exan	niner		Sequentially list conditions,				SUGAR LI	EVELS			
pe	ısit	niner	n any, reading to immediate cause. Enter Underlying Cause (Disease or injury	₹ 509€	ic (or as a consi	equence or;					
8760, cate be executed	prosident and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due t	to (or as a conse	equence of):					
18760, cate be ex	e buri	dical		d.							100
	as the										
Box 6	for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant		outcome of preg		Ectopic pregnanc	v			of delivery
	ne all	sicl	in the past 12 months? 1 ☐ Yes ② No 9 ☐ Unknown		gnant at time of		Other (specify)	,		Mon	th Day Year
ords, P.O	detached f	Phy	Part II. Other significant condi	tions contributing to	death but not re	asulting in the u	nderfying cause on	ven in Part I	23e Did t	obacco use contri	bute to the cause of death?
ds,	5 g	d by	HYPERTEN	3		20411119 111 1110 41	naony my sauso gr			_	3 ☐ Probably 4 ☐Unknown
SOL WIEGE	pluods	lete							24a. Was	an 24h W	/ere autopsy findings available
<u> </u>	nas je 2	Completed							auto	psy pi orm <u>ed</u> ? de	rior to completion of cause of eath?
	rector, pag	Be C	25. Was case referred to media	cal				26 Place of D	1 ☐ Yes		☐ Yes 2☐ No
- 00		0	examiner? 1 □ Yes 2 X No	Hospital:	☐Inpatient 2	ER/Outpatien	t 3 DOA Ott	NO.	Home 5 ☐ Resi		r (Specify)
	Arter this funeral di	Ju: T	27. Manner of Death 1 XNatural 5 □ Pend		te of Injury onth, Day Year)	28b. Time of Injury	28c. Inju	ry at rk?	28d. Describe	how injury occurre	d
/ision Attanding r death.		atlc	2 Accident inves	stigation				Yes 2 □ No			
Division for Attanding after death.	in by the	Certification:	3 Suicide 6 Coul 4 Homicide dete	mined 288. Pld	ice of Injury - At ilding, etc. <i>(Spe</i>	home, farm, str cify)	eet, factory, office		28f. Location ( City or To		r or Rural Route Number,
Hospital of thours af	illed i.		20a Cartifice ST Cartif	ving Physician T	the best of my !	nourlades dest	annumal states of	mo doto and at	and due to the	00upo(a) = c + -	and an atotal
To the Hospital within 24 hours a	to the Funeral Director: completely filled in by the	Medical		ying Physicien: To t al Examiner: On the and ma							ner as stated. nd due to the cause(s)
To the within 2	compl	Me	29b. Signature and title of certification	ier	0.		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
	2		A AZZ	-6-W	the M	D.	DI	9947		AUG.	26, 2004
			30. Name and address of person	on who completed ca	ause of death (It	em 23a) (Type,					
			ANNETTE	GONSALVES			POST OFFI	CE RD.,	SUITE 100	), WALDOI	RF, MD. 20602
F	Sta Registr		31. Date filed (Month, Day, Yea		. Registrar's Sig	J J	Sparke	1			

# CRUPAIN, ELE NATHANIEL Baltimore, Maryland 21215-0036

Please	Type	or	Print	in	Black	Indelible	e Ink.	Ensu	re All	Copies	Are I	_egible
					1 1							

			For Stata Registrar	State of Maryland	/ Departme		Mental Hyg	•
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last)     NATHANTEL     Aa. Facility Name (If not institution, give s	CRUPAIN street and number)	4b. Cit	y, Town, or Location of Dea	2. Date of Deat Month Hugust	3. Time of Death  3. Time of Death  3. County of Death
	Funeral Director		DOCTORS         COMMUNITY           5. Social Security Number         6. Sex           124-12-0836         1			ANHAM er 1 Year If Under 24 Hr. Days Hours Mir		
	he Maryland 28a-f show cuffied at	Director	Usual Residence of Decedent   10a. State   10b. County	_				10d. Inside City Limits 1 Tyes 2 No
036	within 72 hours after death with the Maryland liene. Than "natural", or Itams 23e or 28e-f show The Medical Evantral must be rollied at	by Funeral Dir	7885 GREENBELT ROA  11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 X Yes 2 No If Yes, Give Year or Dates: 1945	13. Was Dec	.0706 edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	U	Og. Citizen of What Country?  NITED STATES  14. Race - American Indian, Black, White, etc.  Specify: WHITE
21215-0036	可語を	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Decedent's Us (Give kind of v life. DO NOT CITY PI	rork done during most of wo use retired)	orking	16b. Kind of Business/Industry  GOVERNMENT
Maryland	d 2 should be filed th and Mental Hygis 7 Is marked othar traumatic evant, It	To Be C	17. Father's Name (First, Middle, Last)  BENJAMIN  CR  19a. Informant's Name/Relationship (Ty,	UPAIN DB, Print)	19b. Mailing Addre	ANNA	LUCILLE  Bural Route Number,	
ē,	permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other trau		URA USCOTT, SISTE  20a. Method of Disposition  1 □ Burial 2 ▼ Cremation 3 ▼ R  '4 □ Conation 5 □ Other (Specify)  21. Signature of Funeral Service License	erroval from State  20b. Placen cen NATI	ce of Disposition (Netery, crematory of ONAL CREING 22. Name DANZAN	AATORY 8/24 And Address of Facility	PALLS CHURCH, VIRGINIA CHAPELS, INC.	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or combined, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. le cause on each line.  PHEU Me  Due to (or as a conseque	Do not enter the mo	ode of dying, such as cardia		
3760,	ate be executed hysician and ihe burial-transit	licai Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent Due to (or a consequent Due to (or a consequent Due to (or a consequent Due to (or a consequent Due to (or a consequent Due to (or a consequent Due to (or a consequent Due to (or a consequent Due to (or a consequent Due to (or a consequent Due to (or a consequent				
P.O. Box 68	The law requires that the death certificate tie has been signed by the attending phys age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 Ectopic			23d. Date of delivery Month Day Year
Hecords, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions cor	SEHAL ULC		cause given in Part I.		acco use contribute to the cause of death? s 2 No 3 Probably 4 Dunknown
Vital Reco		e Completed	PNEU MONI ANEMIA 25. Was case referred to medical	A		26 Place of De	24a. Was ar autopsy perform 1 Yes 2	prior to completion of cause of death?  Julyo 1 Yes 2 No
DIVISION OT VI	Attending Phyaic ar death, actor: After this ce by the funeral direc	Certification; To B	examiner?	T	8b. Time of Injury M	Home 5 Reside	nce 6 Other (Specify) winjury occurred seet and Number or Rural Route Number,	
2	Hospital	Medical Cer	29a. Certifier 1 Cartifying Physical Check only one) 1 Madical Examination	sician: To the best of my knowledge:  nar: On the basis of examinatio and manner stated.	edge, death occurre n and/or investigation	d at the time, date and placen, in my opinion, death occ	e, and due to the ca curred at the time, da	use(s) and manner as stated. Ite and place, and due to the cause(s)
, (	comple	Me	29b. Signature and title of certifier	eren MD	1	9c. License number	36	Date signed (Month. Day, Year)
	Sta Regist		30. Name and address of person who come to the come of		SPITAL	8118 G001	Dluck R	D LANHAMHD 2070

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 5:30 P.M Wayne Cunningham Steven 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11940 Azalea Drive Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral ¼** M 2□F Yrs. 217-98-7291 **Director** 38 Sept. 27, 1965 <u>Maryland</u> Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.
Itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic evant, the Medical Examination and be notified at 1 ☐ Yes 2XXVo Maryland Washington Hagerstown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11940 Azalea Drive 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2**XXX**(No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1□ Yes 2□No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Freight Delivery 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Robert Franklin Cunningham <u>Nettie Jean Whittington</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: if itam 27 ia
any injury or other trau 115 Vienna Way Martinsburg, West Virginia Robert F. Cunningham-Father Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 □ Donation 5 □ Other (Specify) Cedar Lawn Memorial Park Aug.30,2004 Hagerstown, Maryland 22. Name and Address of Facility
Osborne Funeral Home, P.A.
21795
425 S. Conococheague St. Williamsport, Maryland 21. Signature of Juneral Service Lie n 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Laman menths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 ☐ Yes 2 1 The 3 ☐ Probably 4 ☐Unknown certificate has been si rector, page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 1 Yes 20 funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Certification; To 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

within 24 hours at To the Funeral D completely filled i

Unningham

State Registrar (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

dan 32. Registrar's Signature

DHMH 17 Rev 1/2001

Boarde

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 26,2004 **Physician** Eugene Corum Clarence 11:45AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1, M 2□ F Yrs. Director 278-18-9583 86 March 18,1918 Ohio Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exercities must be notified at Maryland Prince George's 1 Yes 2 No Director Oxon Hill 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ö U.S.A. 20745-1232 5810 Woodland Drive Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X□ Yes 2 □ No 1943— 17 Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced 1946 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ith and Mental Hygiene. 27 is marked other than "r r traumatic event, I'm Med Elementary/Secondary (0-12) 12 College (1-4or 5+) Physicist/Mathematician Naval Research Lab. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Lvda Green Cantrell Clarence Elliott Corum ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 is eny injury or other trainonce. Teresa H. Corum (Wife) 5810 Woodland Drive Oxon Hill Maryland 20745-1232 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August 27, 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State Lee Crematory Clinton, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signature of Funeral Service 22. Name and Address of Facility Lee Funeral HOme. Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SUALUOUNE /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Attending Physician: The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Box 68760, Physician/Medical asi attending p IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. by the a 9 Unknown 9 Unknown à signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 2 10 1 Yes 3 Probably 4 Unknown Completed peeu 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has certificate has lirector, page 2 2 2 No 1□ Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide ō within 24 hours aft To the Funeral Di completely filled in Hospital certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) 119431 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name a d ade Myster 1st 1/03 FT. Was hughen MD State 2004 Registrar

Brad Cummins UNK 04-274 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend Item #23a&27 per me C835 9/2/04 tas Beg. No. 04-05243 **RPD** Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death August 12, 2004 **Physician** BRAD CUMMINS 1148 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE CITY 2000 Block Cylburn Avenue Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** DECEMBER 1, 1964 NORTH CAROLINA Months Days Hours Min. 1₩ M 2□F Yrs. 39 231-27-5897 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County rai', or items 23e or 28a-f show Examinar must be notified at 1 ☐ Yes 2 XNo Director BALTIMORE WINDSOR MILLS the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with UNITED STATES 2041 WISPER WOODS WAY 21244 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 24 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. should be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced RIACK "natural", Hygiene. other then "nature ent, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LICENSED CONTRACTOR CONSTRUCTION other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 is marked of treumatic ever WILLIAM CIMMINS JEANNE HARRIS CUMMINS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BRENDA FORD/SISIER 5005 HENDERSON ROAD, TEMPLE HILLS, MD 20748 item 27 i 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Importent: If its any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State THE HUNTT CREMATORY AUG 30, 2004 WALDORF, MARYLAND \* 4 □ Donation 5 □ Other (Specify)

1. Since the of Fune (Service Canal) THORNION HIMFRAL THOME, P.A. 3439 LIVINGSION ROAD, INDIAN HEAD, MD 20640 INDIA C. THORNION JOHNSON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia associated with drug use **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed resulting in death) Last Due to (or as a consequence of): burial Box 68760. physician Physician/Medical the as IF FEMALE use a 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy that the death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year ō Dav 5 Other (specify) 4☐Pregnant at time of death P.O. the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Yes 2 No 2 No Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) iner Hospital: 1 Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$ Other (Specify) At SCENE 2 ER/Outpatient 3 DOA 1XXYes P 2 No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attending 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 August 13, 2004 O.C.M.E. (4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 THEODORE M. Ki. MF 32. Regularar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/200

Registrar

Margare.

AUG 3 0 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer **Physician** Joseph Calabro 7:25 P M Leonard August 27, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6829 Cologo Court Waldorf Charles 6. Sex 1 M M 2 ☐ F If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthptace (State or Foreign Country) Months Director 184-10-9696 91 1912 Pennsylvania Usual Residence of Decedent death with the Maryland , or Itams 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes No Directo Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6829 Cologo Court 20603 Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No r than "natural, or Itams to Medical Execution" 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: δ Specify: 3 

Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, It a Market in the Elementary/Secondary (0-12) College (1-4or 5+) Salesman 10 Retail Shoes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mateo Calabro Roseale Reale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard M. Calabro - Son 6829 Cologo Court, Waldorf, MD 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State The Huntt Crematory 9-1-04 4 □ Donation 5 □ Other (Specify) Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01391 Huntt Funeral Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TISKNOSCLEMOSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner IR RELUNGTIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Obsease or injury that initiated events Examine as the burial-transit The faw requires that the death certificate be executad 21 15 resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) the 9 Unknown 9 Dunknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 2 No 2 🗌 No 1 🗌 Yes : After this certifical funeral director, r To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 21 No Other: 4 Nursing Home \*\* Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina hours after death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Diractor: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medica 2 Medical Examiner: On the basis of examination and and manner stated. (Check only one) or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) derson who completed cause of death (Item 23a) (Type, Print) MPS 11345 Pembrooke Sq. #103, Waldorf, MD 20603 George H) Wathen, 31. Date filed (Month, Day, Year) State Registrar 2004 AUG 3 1

			For State Registrer	State of N		artment of Health and rtificate of Death	,,,	ene g. NoD () ()	0.0.2.
			Decedent's Name (First, Middle, Last)	)			2. Date of Death		3. Time of Deathi
П	Physicia	an	Tima.	C.	h 1 ±		Month	Day Year 24 2004	0 - 20 - M
	/Medic		Linda Lou  4a. Facility Name (If not institution, give		henault <sup>97)</sup>	4b. City, Town, or Location of D	<u>August</u>	24 2004 4c. County of Death	9:30 p "
	Examin	er	970 Bowie Shop Roa		,				L
-	Funeral		5. Social Security Number 6. Sec		Age (In yrs. /ast birthday,	Huntingtow If Under 1 Year If Under 24 I	Hrs. 8. Date of Birth	Calve 9. Birthp	lace (State or Foreign
	Funeral Director			]M 2 <b>∏</b> F	53 Yrs.	Months Days Hours N	Min. (Month, Day, Dec 21.	Year) Cour 1950 Virg	itry)
			Usual Residence of Decedent		33	<u> </u>	- Dec 217		
	ylan how		10a. State 10b. County		10c. City, Town or L	ocation		1	Od. Inside City Limits
	a-fa	cto	MD Calvert			Huntingtow	n		1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number			10f. Zip Code	10	g. Citizen of What Cour	ntry?
	th wi	a	970 Bowie Shop Roa	d		20639		USA	
	ems	Funeral	11. Marital Status	12. Was Decede Armed Force	ont Ever in U.S. 13.	Was Decedent of Hispanic Origin's If Yes, specify Cuban, Mexican, Pr	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Americ Black, White,	
9	after or it	F	1 Never Married 2 Married	1 ☐ Yes 2 f	XNo	1 ☐ Yes 2 X No Specify:		Specific	
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2	Hygie thar nt,		17. Father's Name (First, Middle, Last)		Cas		Name (First, Middle, M		COLE
ano	ould be filed within 72 hours after death with the Maryland Mental Hygiene.  arked other then "natural", or items 23e or 28e-f ahow attic event, the Medical Evantarian must be notified at	Be c		_			_		
Maryland 21215-003	should ind Men s marks umatic	20	William Henry  19a, Informant's Name/Relationship (T)		arson 19b. Maif	ng Address (Street and Number of			Code)
<u>8</u>	d 2 s th an th an t7 is trau		William S. Chenau		1				0639
Ġ,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f ahow any Injury or other traumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition	IL, UL.,	20b. Place of Disp	osition (Name of		Oc. Location - City or To	
Baltimore,	Pages nent of I int: If it	1	1 Burial 2 Cremation 3 F		110	matory or other place)   Litan Crematory	0/20/04	Aloumandada	777
量	it. P		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> </ul>			2. Name and Address of Facility	0/20/04	Alexandria,	VA
Ba	permil. Departr Imports any Inj		) /N. O	Gan		ausch Funeral H	ome DA	Owings M	20736
	_		23a. Part1. Enter the disease, or complete	ications that cau					Approximate
П			shock, or heart failure. List only of Immediate Cause (Final	ne cause on eacl	h line		,,		Interval Between Onset and Death
	Pnysician /Medical	Ĭij	disease or condition resulting in death)	a	COPI	) severy			10 years
	Examiner			Due to (or	as a consequence of):	16			
		<u></u>	Sequentially list conditions,	Due to (or	as a consequence of):				
	ted	ulu ulu	if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events	`					
	al-tra	Examiner	resulting in death) Last	Due to (or	as a consequence of):				
8760,	cate be executed oblysician and the burial-transit	dicalE		d					
687		olbe		4.					
	eath certific attending p	W/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor				23d. Date of delive	erv
Вох	that the death led by the atter detached for u	clar	in the past 12 months? 1 □ Yes 2 No			□Ectopic pregnancy □ Other (specify)		Month	Day Year
o.	the c y the	lys	9 Unknown	9□ Unknow	n				
۵.	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions co	ntributing to deat	h but not resulting in the	anderlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
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Vital		e C	25. Was case referred to medical			26 Place of	1 ☐ Yes 2		2   No
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of	Phys r this aral di	. To	27. Manner of Death	28a. Date of I	njury 28b. Time o	of 28c. Injury at	28d. Describe how		//
O	iding Ph th. : After th funeral	tlor	1 Natural 5 Pending investigation	(Month,	Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division of	Attanding r death. actor: After by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of	fnjury - At home, farm, si	reet, factory, office		et and Number or Rura	l Route Number,
ă	after Dira	erti	4  Homicide	building	, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attanowithin 24 hours after death To the Funeral Diractor:	edical C	(Check only 2 Medicel Exami		use(s) and manner as si te and place, and due to				
	To the within 2 To the complet	Med	29b. Signature and title of certifier	29	d. Date signed (Month,	Day, Year)			
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	10				of death (Item 23a) (Type	TRINCE FREILE	ich mi	170	
	10		31. Date filed (Month, Day, Year)	32. Reg	istra Signature	INCO PRENE	uce in	20618	
	Sta Regist		AUG 2	6 2004	Signature	South			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** JOHN CRABBE AUGUST 23, 2004 7:21P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CLINTON NURSING AND REHABILITAION CLINTON PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1**XX**M 2□F Yrs. Director 231 12 0777 82 1921 VIRGINIA Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumetic event, the Medical Examinar must be notified at XIX Yes 2 No Directo MARYLAND PRINCE GEORGES CLINTON 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? 9211 STUART LANE e filed within 72 hours after death in Hygiene.
other than "natural", or items 23s 20735 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes XX No If Yes, Give Year or Dates: XX Never Married 2 Married 1 Yes XX No ð Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9TH LABORER PRIVATE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth any injury or other treumetic event 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROBERT CRABBE MARY WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA THOMPSON / DAUGHTER TEMPLE HILLS, MD 20747 4704 TEAK COURT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) ZION CHURCH CEMETERY 28 AUG 04 KINSALE, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD / FISHER FUNERAL YV HOME 4308 SUITLAND ROAD SUITLAND, MD 20746 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** CARDIOPULMONARY ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) led by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4XXInknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has 1 ☐ Yes XX No Be 25. Was case referred to medical 26. Place of Death (Check only one, Other: XX Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes ZXXNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation the Hospitel or Attending 1XXVatural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0024208 200

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records.

Division of Vital

31. Date filed (Month, Day, Year)

AUG 2 7 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9211 STUART LANE

2. Registrar's Signature

CLINTON, MD 20735

	,		1 - For State Registrar AMEND ITEM	State of M. #19c. \$15 #17818 PE		Departme			Mental Hy	giene Reg. No. 2	01.	28652
}	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, La  1. Decedent's Name (First, Middle, La  4a. Facility Name (If not institution, giv	sleman	Jh	4b. City	, Town, or Lo	cation of Death	2. Date of De Month	it 21,2	Year OOY of Death	Time of Death
	Funeral Director	ici	5. Social Security Number 057–22–8673	Sex 7. Ag	e (In yrs. last to	pirthday) If Under Months		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da November	th ay, Year)	9. Birthplace Country) New York	e (State or Foreign
	Maryland 8-f show	tor	Usual Residence of Decedent  10a, State  Maryland  10b. County  Prince Ge	orge's	10c. City, To	wn or Location	Seat	Pleasar		4	10d.	Inside City Limits 1X Yes 2 □ No
	s 23a or 28	ral Director	10e. Street and Number 814 Booker Place	l com B	5			0743		10g. Citizen of V	Α.	
900	hours after death with the Maryland turel', or Items 23s or 28s-f show at Examiner intertibled at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1/MYes 2 ☐ If Yes, Give Year or Dates:	No	13. Was Deci	1777	anic Origin? (5 Mexican, Puert	pecify Yes or No p Rican, etc.)	Blac	e - American k, White, etc. Black	
21215-0036	d within 72 piene. r then nat	Completed	15. Decedent's E (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or		a. Decedent's Usi (Give kind of w life. DO NOT Superviso:	ork done duri use retired)	ng most of wor	king	16b. Kind of Bu		ent (Retire
Maryland	should be filed nd Mental Hygi marked other umatic event, I	To Be C		Coleman, Sr.					<del>Iula Co</del>		ILA HUI	
	d 2 s th ar 7 to		19a. Informant's Name/Relationship (Denise C. Evans (Daug	Type, Print) hter)	19	9b. Mailing Addres 3910 <b>Kensi</b> i	is (Street and ngton Pa	rkway Ch	ral Route Numb Evy Chase	er, City or Town, , Maryland	State, Zip Co. 2081.5	de)
Baltimore,	of F of F if ite		20a. Method of Disposition  1XXXBurial 2 Cremation 3 C  4 Donation 5 Other (Special		cemet	of Disposition (Na ery, crematory or rection Cer	other place)	Augus	Date 28,2004	20c. Location - Clinton,		
Balt	permit. Pag Department Important: sny injury o		21. Signature of Funeral Service Lice	-mae	sex	4339 H		e, N.E. J	whshingta		, Inc. 0019	
8760,	Physician /Medical Examiner  the purial-transit the	dical Examiner	stock, or heart failure. List only Imm late Cause (Final disease or condition resulting in death)  Sequentially list conditions, in any leading to make a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for as c. Due to for as d.	a consequence	shock e of): e of): for f e of):	e ilu	Te.				ierval Between nset and Death
.O. Box 6	death certifi e attending   d for use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal dea	th 3 Ectopic   5 Other (s			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	23d. Date Mor	e of delivery oth Day	y Year
ords, P	w requires that the been signed by th should be detache	by P	Part II. Other significant conditions	contributing to death b	out not resulting	in the underlying	cause given i	n Part I.		robacco use contr Yes 2⊠No		
Vital Record	The law ate has b page 2 st	e Completed							1 ☐ Yes	psy prmed? d	rior to comple leath?	findings available etion of cause of
of	Attending Physician: r death. sctor: After this certific. by the funeral director.	To B	25. Was case referred to medical examiner?  1 Yes 2 XNo  27. Manner of Death 1-X Natural 5 Pending 2 Accident investigation	Hospital: 1 patii 28a. Date of Inju (Month, Da	ıry 28b	Outpatient 3 C Time of Injury	OA Other: 28c. Injury at Work?			one) dence 6 ①Othe		
Division	in Dirt	Certification:	3 Suicide 6 Could not be determined	289. Place of in	jury - At home, ic. <i>(Specify)</i>	farm, street, facto	ry, office	10	28f. Location ( City or To	Street and Number wn, State)	er or Rural Ro	oute Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier Certifying Pl (Check only one) Medicel Exe	hysicien: To the best miner: On the basis o and manner st	of examination a	ge, death occurre and/or investigatio	d at the time, n, in my opini	date and place on, death occu	, and due to the rred at the time,	cause(s) and mad date and place, a	nner as stated and due to the	d. e cause(s)
•	To the vithin 2 To the comple	Me	29b. Signature and the of certifier	les		29	253	STU		AUSUS	1	
C	R/15		S.tevel-	completed cause of	vert	(Type, Print)	3001	Hospital		everly, Ma		
	Sta Regista	_	31. Date filed (Month, Day, Year)  AIIG 2 7 2004		rar's Signature	hours.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Angela N. Dali August 19, 2004 9:20 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Rehab. & Nursing Ctr. Burtonsville Montgomery If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 21X F Director April 1,1918 NY 105-01-6239 Usual Residence of Decedent the Maryland 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo NY Onondaga Syracuse 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 244 Medford Avenue 13208 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itan any inlury or ojber traumatic event, the Medical Examiren ones. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Cafeteria Manager Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anthony Froio Rose Procopio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard S. Dali - Son 12900 Saddle Brook Dr., Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Aug.21,2004 Syracuse, NY Woodlawn Cemetery ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. N.W. Wash., D. C. 20016 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Glioblastoma resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🛣 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe within 24 hours after death.

To the Funaral Director: After this completely filled in Experimental Complete certificate 1 ☐ Yes 2₺ No 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52261 August 19, 2004

Registrar

State

AUG 23 2004

Alan R. Segal, M.D.

30. Name and address of person who completed call

31. Date filed (Month, Day, Year)

39. Registrar's Signature & Sparks

1517 Hugo Circle Silver Spring, MD 20906

e of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day Yeer **Physician** Ам JOSEPH ALBERT DARLINGTON 2004 AUG 22 8:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 27, 1 Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min 1 X M 2 □ F Yrs. 577-38-1461 76 1928 Washington, Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show 10d. Inside City Limits the Medical Examiner: ust be notified at Director 1 ☐ Yes 2 X No Gaithersburg Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? with 5 'natural', or Itams 23a 19030 Quail Valley Blvd. 20879 death United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Exercited and any injury or other traumatic event, the Medical Exercited and any injury or other traumatic event, the Medical Exercited and any injury or other traumatic event, the Medical Exercited and any injury or other traumatic event, the Medical Exercited and any injury or other traumatic event, the Medical Exercited and any injury or other traumatic event, the Medical Exercited and any injury or other traumatic event, the Medical Exercited and any injury or other traumatic events. 1946-1 Never Married 2 Married 1X Yes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 21K No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced 1973 White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Civil Engineer U.S. Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles ပ Elmer Darlington Florence May Sears 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19030 Quail Valley Blvd., Gaithersburg, MD. 20879 Margaret A. Darlington/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery | 8/26/2004 | Suitland, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC RECTAL CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ Year in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the detached 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate Division of Vital 1 Yes 2**X** № Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2X No 1 Nnpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation injury 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide after 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. within 2 the 29b. Signature.and title of certifier 29d. Date signed (Month, Day, Year) 2 23, AUGUST 2004 MD 229179 (NY) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 241 NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 SAM W. GAO LT 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar AUG 24

DHMH 17 Rev 1/2001

2004

			Please I	State of Maryla				•		_	
			For State	State of Maryla	-	rtificate of			_	2001	00000
			Registrar  1. Decedent's Name (First, Middle, Last,	)		imouto or	Douth	2. Date of De	Reg. No	2006	3. Time of Death
П	Physici /Medic		MINERVA JAN	& DAVIS	S			AUGU	ST I	7,200	4 1710 M
	Examin		4a. Facility Name (If not institution, give	street and number)			or Location of Dea		40	County of Dea	
		٠			OSPITAL		154				TOMERY
	Funeral Director		0 0. 3000	x	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min	. (Month, Da	y, Year)	9. Bir 2,1919 1	thplace (State or Foreign ountry) Pennsylvania
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	ocation					10d. Inside City Limits
	Mary Fied sh	tor	Maryland Montgomer	-v S	andy Sp	ring					1 ☐ Yes 2 ☐ No
	or 28e	Director	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What C	ountry?
	ath wi	ral	1641 Hickory Knoll	Road		20860			USA		
	er dez	Funeral	11, Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No rto Rican, etc.)	-	14. Race - Am- Black, Whi	
336	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 🗍 Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:			Specify: V	√hite
2-0	be filed within 72 hours after death with the Maryland tal Hygiene. do other then "neturel", or Items 23e or 28e-f show event, the Medical Examinar must be notified at		15. Decedent's Edu (Specify only highest grad	ication	16a. Dece	dent's Usual Occup	pation	odeina	16b. K	ind of Business	/Industry
21	within 7 ene. then "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	лки			
2	e filed within al Hygiene. cther then " vent, the We		12 17. Father's Name (First, Middle, Last)		Вс	okkeeper		me (First, Middle,		etail Sa	ales
and	d be fantal h	o Be	Fred Worthington					e Rosenb			
Maryland 21215-0036	2 should be and Mental is marked e	2	19a. Informant's Name/Relationship (Ty	/pe, Print)	19b. Mailin	ng Address (Street	<u> </u>				Zip Code)
	alth a		Don Davis/Son		2514	Jackson	Parkway;	Vienna,	VA.	22180	
Baltimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		Place of Dispo cemetery, crei	osition (Name of matory or other pla	ce)	Date	20c. L	ocation - City or	Town, State
ţ	:. Pag tment tent: jury c		'4 Donation 5 Other (Specify)	Fo		coln Ceme		ust 21,2	004	Brentwo	ood, MD
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic engines.		21. Signature of Furieral Service kicens	1 Vanil	S	2. Name and Addre imple Tri	bute Fun	eral and	Cre	emation	Center
*	6:		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the dea	ath. Do not en	er the mode of dy	ng, such as cardia	e Rocky ic of respiratory ar	rest, 16	e, MD 20	roximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A CUTE PU							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	,						
		<u>-</u>	Sequentially list conditions,	b. ACUTE III		RDIAL	INFARC	TON	-		MINUTES
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CORONAL		man D	NSEASE	7			WEARS
o,	be executed ician and burial-transit		resulting in death) Last	Due to (or as a conse							1-,
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x 68	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as the	Physician/Medi	IF FEMALE:	20- 16			-				
Вох	attenc for us	lan/	in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of	tal death 3	Ectopic pregnanc Other (specify)	у		ľ	23d. Date of de Month	livery Day Year
P.O.	that the dead by the detached	ysk	1 ☐ Yes 2 💆 No 9 ☐ Unknown	9☐ Unknown	douin 3E						
	res that igned b	by PI	Part II. Other significant conditions con				ven in Part I.	23e. Did to	obacco (	ise contribute to	the cause of death?
Records,	w require been sig should b	ted t	TYPE 2 DIAP	beres mer	UNIS	; HYPG	RTEN-	1 🗆 Y	es 2	MNo 3∏Pi	robably 4 Dunknown
ecc	has be	Completed	SION					24a. Was autop	SV	prior to	utopsy findings available completion of cause of
E H		Con						perfor	rmed? 20 No	death?	2 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott		ath (Check only o			
oţ		7: To	1 XYes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	≥ER/Outpatier 28b. Time of	28c. Inju	ry at	Home 5 ☐ Resid			cify)
ion	uttending death. ctor: Afte y the fune	atlor	1 Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury	M 1	rk?  Yes 2∐No				
Division of	Hospitel or Attending 4 hours after death. Funerel Director: Afte tely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location (S City or Tow	Street an vn, State	d Number or Ri	ural Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kr ner: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the ti vestigation, in my o	me, date and place	e, and due to the curred at the time, o	cause(s)	and manner as I place, and due	s stated, to the cause(s)
	To the h within 24 To the F complete	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Dat	e signed (Mont	h, Day, Year)
	->-0		1 Commis	ATTENDIPO	- PHYSIC	IAD DE	12046		Aud	JUST 1	8,2004
	V		30. Name and address of person who co	ompleted cause of death (Ite	em 23a) (Type,	Print)	0 -				
			30. Name and address of person who co GRACE BROOKE HAFF	MAN, 4.D. 1810	DO SLAI	Se ScHoo	L KOAD S	SANDYS	PRIN	SG. MA	RYLAND 20860
	Sta Registr		31. Date filed (Month, Day, Year) AUG 27 20	JZ, mayistiai s Sigi	nature	Spork	V	•			•

			For State of Maryla  1 - State Registrar		artment of He <i>tificate of D</i>			giene leg. No/> () ()	0000
ı	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Aubrey  Leroy	7	Dorsey		2. Date of Dea Month August	th 2004	3 Time of Death / 0646a M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L			4c. County of D	
			Frederick Memorial Hospital	rs. last birthday)		erick If Under 24 Hrs.	O Data of Birth	Frede	
	Funeral Director		5. Social Security Number 6. Sex 1 3M 2 F 6	**	Months Days	Hours Min.	8. Date of Birth (Month, Day	7000	Birthplace (State or Foreign Country)
h			Usual Residence of Decedent				Aug.7,	1938	Maryland
	anylan show	_		City, Town or Lo	cation				10d. Inside City Limits 1X Yes 2 □ No
	Ba-f	Director	MD Montgomery	Во	yds			10 - Oiling - 114th -	
	with t	Dir	10e. Street and Number 19500 White Grounds Roa	a	10f. Zip Code	841	[ '	U.S.A	
	death ms 23	Funeral	11 Marital Status 12. Was Decedent Ever in		Was Decedent of Hisp f Yes, specify Cuban,		ecify Yes or No-		merican Indian,
030	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or itams 23a or 28a-f show adent. The Mediral Examinar must be molified at	by	1 ☑ Never Married 2 ☐ Married  1 ☑ Never Married 2 ☐ Married  1 ☐ Yes 2 ☑ No  If Yes, Give  Year or Dates:	1	fYes, specify Cuban, 1□Yes 2√□No	Specify:	Hican, etc.)	Black, W Specify:	hite, etc. Black
215-0036	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupati	on rina most of work	rina	16b. Kind of Busine	ss/Industry
7	nithin ne. han "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	life.	oo not use retired) ruck Drij			Accu B:	
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Maryland	Mental Mental arked o	To Be	Aubrey C. Dorsey				Mae Gr		
3	should be and Menta marked umatic av	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ig Address (Street an	d Number or Rur	al Route Number	r, City or Town, State	e, Zip Code)
	and 2 ealth a n 27 is		Michael Plummer (Son)	9341	Merust 1	Lane, (	Gaither	sburg, 1	MD 20879
Baltimore,	of He of He if item or oth		MXBurial 2 ☐ Cremation 3 ☐ Removal from State?		natory or other place)			20c. Location - City	,
Ē	trant of tant: If it		• 4 □Donation 5 □Other (Specify)		ks Cemete			Boyds,	
g R	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injuryer other traumatic as once.		21. Signature of uneral Service Licens		246 N. Wa				HOME, P.A. MD 20850
	Physician /Medical Examiner	Examiner	23a. Part. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, leave leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a constitution of the condition of the	equence of:					Approximate Interval Between Onset and Death
P.O. Box 68/60,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   Un	gnancy etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	s that pned b	by Pt	Part II. Other significant conditions contributing to death but not	esulting in the u	nderlying cause given	in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
ord:	w require been sig should b		Essential Hypertension				1 🗆 Ye	es 2□No 3□	Probably 4XXXnknown
Reco	The law re ate has be bage 2 sh	Completed	Prostate Cancer				24a. Was a autops perform	y prior	autopsy findings available to completion of cause of ?  'es 2 \sum No
Ital		BeC	25. Was case referred to medical examiner?				h (Check only on		
n of v	Attending Enysician: The law r death. ctor: After this certificate has y the funer I director, page 2	ို	1	28b. Time of	28c. Injury a Work?	it Isansing H		ence 6 Other (S	pecify)
Division of Vital Records,	l or Attendate death Dir ctor:	Certification	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, str ocify)		s 2 □ No	28f. Location (SI City or Town		Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dircompletely filled in	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my leading to the best o	nowledge, death	n occurred at the time, vestigation, in my opin	, date and place, nion, death occur	and due to the cared at the time, d	ause(s) and manner ate and place, and c	as stated. fue to the cause(s)
)	To th withir To th comp	Me	29b. Signature and title of certifier	~	29c. License r D3516		2	9d. Date signed (Mo August 1	·
	ا ا		30. Name and address of person who completed cause of death (I Andrew Zarick, Jr, M.D., 15			et, Fre	derick.	Maryland	21701-4501
	Sta Regist		31. Date filed (Month, Day, Year) 32. Redistrar's Sig		Sparks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Aug 27, 2004 Gilbert Dean 14:20 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Clinton Southern Maryland Hospital Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year **Funeral**  Birthplace (State or Foreign Country) 17 M 2□ F 578 38 5348 Director 76 Yrs Oct 20. 1927 Washington DC Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mcdical Examinar must be mailfied at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland | Prince George's Clinton 10e. Street and Number 10f. Zip Code Apt 906 10g. Citizen of What Country? 8600 Mike Shapiro Drive 20735 United States Compieted by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian e filed within 72 hours after de il Hygiene. other than "natural", or Item Black, White, etc. XIXYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Payroll Clerk Mariott Corp 12 should be fited v h and Mental Hygie 7 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Spencer Dean Sybil Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 Is any injury or other train once. James W. Dean (Brother) 9805 Healy Court, Upper Marlborn, Md 20772

Bate Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Resurrection Cemetery Sept 2, 2004 Clinton, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Fur eral Service Licensee Alexandria Ferry Rd, Clinton, Maryland 20735 (del) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** ptic disease or condition resulting in death) /Medical Due to (or as a donsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed use as the burial-transit ed by the attending physician and detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 1 Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Chack only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient this 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? Hospital or Attending 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 24208 30. Name and address of person who completed cause of death (Item 23a) (Type, Frint) 34 ABULH ASAN into Mc

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

AUG 3 0 2004

8/27/04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death -1. Decedent's Name (First, Middle, Last) August 22, 2004 **Physician** 12:15 A M Jean Norment DeVault /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Frederick
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Calvert County Calvert Memorial Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 200 F 79 578-24-1903 1924 Washington, D.C. 5, Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits a filed within 72 mouse...
If Hygiene.
I other then "natural", or items 23a or 28a-f show svent, it a Medical Examinar must be notified at 10a. State 10b. County 1 ☐ Yes 2 No Owings Directo MD Calvert Co. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20736 7709 Lakeshore Drive by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, III... Metallurgy Research Technician Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Quisenberry 2 Gavin Norment 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7709 Lakeshore Drive, Owings, Maryland 20736 Richard E. DeVault (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 25, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ematory 2004 Clinton, Maryland
22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lee Crematory 21. Signature of Funeral Service Licensee 8125 Southern Maryland Blvd., Owings, MD 20736 Michael W. Lee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition INTERSTITIAL WEEKS CUNG DISEASE **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physicien Completed by Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown EIBRILL ATION 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 this certificate has autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ▼ npatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 27 No Certification: To filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 040370

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

110 Hospital Road, Prince Frederick, Maryland 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Wisniewski,

31. Date filed (Month, Day, Year)

M.D.

2004>

32. Registras Signature

August 23, 2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2004 **Physician** Month Year Ridley Frank Durham, Sr 18:54 24, Aug. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X**M 2□F Director 67 239-52-9649 24. 1936 N. Carolina Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Prince George Ft. Washington 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 USA 9604 Glen Way by Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or lian any injury or other traumatic event, the Medical Eventua Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DC Armory Bd. Painter 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Rose Wilder Archie Durham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 9604 Glen Way, Ft. Washington, MD 20744 Mary L. Durham/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 8/30/04 Clinton, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig of Funeral Service Ligar see 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd, Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Corcinoma of kung disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to infinadiate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner as the burial-transit attending physician and resulting in death) Last Division of Vital Records, P.O. Box 68760 death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 22 No 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funaral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) paris P. Jamond 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7700 OLD BRANCH ONE COOR CHIMON, PERNANDEZ ROSARIO

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 7 2004

		1 - For Amend It Registrar	ens 2.		oa i pe	Ce	tificate of t	Death			Reg. No.		
Physici	an	1. Decedent's Name (First, M	iddle, Last)							2. Date of De Month	path Day	Year	3.)Time of Death
/Medi		Darce J. Da					# 00 T	. ( 6	( D 1)	June	28	2004	03:15
Examir	er	4a. Facility Name (If not institu					4b. City, Town, or	~				unty of Death	1
Eumanal		Harford Mer 5. Social Security Number	norial 6. Sex		7. Age (In yrs. la	ast birthday)	Havre d	If Under 2	4 Hrs.	8. Date of Bi	th	rford 9. Birth	place (State or Foreign intry)
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death ms 2	Funeral	116 S. Unio			dent Ever in U.S	6. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig	in? (Spe	cify Yes or No		Race - Amer Black, White	
Dalilillore, Infal ylailid ZIZI3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show may injury or other traumatic event, the Medical Examinan must be notified at ance.		1 Never Married 2 ★		1 ☐ Yes If Yes, Giv Year or Da	2 X No	+	1 ☐ Yes 2 ☑ No	Specify:	ruentor	ricali, etc.)	Sp		nite
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s 1 and 2 f Health item 27 othar tra		20a. Method of Disposition			20b. Pla	ace of Dispo	sition (Name of natory or other place		D	ate	20c. Locat	ion - City or T	own, State
Page nent o		1 ⊈Burial 2 ☐ Cremati 1 ☐ Donation 5 ☐ Othe		moval from			Mem.Grd		/1/0	)4	Aberd	leen, I	Md.
permit. Pages 1 a Department of Hea Important: If item any injury or otha once.		21. Signature of Juneral Serv	ice Licensee	ño		l 22 N	Name and Addres	s of Facility	une	eraL Ho	ome,P.	. A .	
2 60340		23a. Part1. Enter the disease	0.00	ations that c	aused the death	Do not ent	23 S. Wa	shing	ton,	Havre	de Gr	nce, M	A 21078 Approximate
Physician		Immediate Cause (Final	List only one	cause on e	ach line.	lovia	Bill	: 12	un	16			Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a.	Due to (	or as a conseque	ence of):	- Man	N COL	g				700
Examiner		Sequentially list conditions,	b.		L	055 0	Blood.			$\mathcal{M}$	_		/who.
p ii	Iner	if any, leading to immediate cause. Enter Underlying	1	Due to (	or as a consequ	ence of):			//				
cate be executed physician and the burial-transitions	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (	or as a conseque	ence of\:		9		MEDICILEUM	MINER		
d / oU, cate be execu physician and the burial-tra				000 10 (	or <b>as</b> a someoqu	0.100 017.			OVED BY	MEDICA			
licate phys s the	edical	X	d.				1170-0	CHANNE NOV	140				
death certifi e attending d for use as	√Me	IF FEMALE: 23b. Was decedent pregnant	23		come of pregnan						23d.	. Date of deliv	ery
death e atte	by Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No		4☐Pregn	irth 2 Tetal ant at time of dea		Ectopic pregnancy Other (specify)					Month	Day Year
that the de ed by the detached	hys	9 🗆 Unknown		9 Unkno							1		_
S, T		Part II. Other significant con-	ditions contr	ributing to de	eath but not resul	Iting in the u	nderlying cause give	on in Part I.		23e. Did t			the cause of death?
HECOTOS, he law requires t e has been signe age 2 should be	Completed		10.		( ) CIEPONI	Sec	· / // a.	100					
Hec e law has b	ď		Casaca	VIC AS	PIRATION	, Cos	of KINNE	A RE-	_	24a. Was autor perfo		4b. Were auto prior to co death?	opsy findings available empletion of cause of
_ ta d			Rivin	4 DIA	124515 -		0			1 ☐ Yes	2 □ No	1 🗆 Yes	2₽No
	o Be	25. Was case referred to med examiner?  1 Yes ZZNO		spital:	npatient 2 E	EB/Outpaties	t 3 DOA Othe			<i>(Check only o</i> ne 5 ☐ Resi		Other (See	6.)
g ag af ag a	n: To	27. Mann Death		28a. Date of	of Injury	28b. Time of	28c. Injury Work	_	-	8d. Describe			(y)
Attending Ph r death. actor: After th by the funeral	atio		nding estigation		h, Day Year) 19,2004	Unkno		ຕ Yes 2 <b>5</b> 7N	· Th	erapeut	ic mi	sadven	ture
JIVISION  I or Attending after death. Diractor: After in by the fune	Certification:	3 Suicide 6 □ Co	uld not be ermined	28e. Place buildir	of Injury - At hor	me, farm, str	eet, factory, office		145	City or Tox	vn State)		al Route Number,
rs afte	Cer			Ho	spital					artord	Memor:		
TO the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	edical	29a. Certifier Certi (Check only 2 Medi	fying Physical Exemine	cien: To the er: On the ba and mann	asis of examinati	vledge, deati on and/or in	occurred at the time restigation, in my op	e, date and pinion, death	place, a occurre	ing due to the ed at the time,	cause(s) and date and pla	manner as s ce, and due t	stated. o the cause(s)
Fo the within Fo the complex	Me	29b. Signature and title of cer	ifier /	/			29c. License					gned (Month,	
		<b>&gt;</b> ////	an/ha	m			194	1092	Z_	_	Jun	1E,28	2004
(h) h		30. Name and address of per	son who cop	ipleted caus	e of death (Item	23а) (Туре,	Print)	11 -		. !!	0	-,,	,2004 1D
(1)		DR. M	M VI	MACHS	MAN, M.	D, PhD	407 5.	Union	A	Ve. HAV	Redel	1RACE!	1D
Sta	- 1	31. Date filed (Month, Day, Yo		32. R	egistrar's Signati	ure							
Regist	ar	CED 0 3 200		20.00	4	do	100						

DHMH 17 Rev 1/2001

Davison, Darce

M. Wallsman,

	1 - State Registrar State of Maryland / Department Certificate	t of Health and M e <i>of Death</i>	ental Hygiene	
Physician	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	Year
/Medical Examiner	John Daniel Enslow  4a. Facility Name (If not institution, give street and number)  4b. City,	Town, or Location of Death		004 11:30 P M
Cxaminer		thesda	Mont	tgomery
Funeral Director	5. Social Security Number 220−84−8531 6. Sex 7. Age (In yrs. last birthday) 44 Yrs. If Under Months	Days Hours Min.	8. Date of Birth (Month, Day, Year) July 29, 1960	9. Birthplace (State or Foreign Country)  Maryland
and *	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
death with the Maryland ms 23a or 28a-1 show froust to martified at neral Director	Maryland Prince George's Laurel			1 ☐ Yes 2% No
with the Ma	10e. Street and Number 10f. Zip	Code	10g. Citizen of	What Country?
23a o	885 Talbott Avenue 20	0707	US	SA
of the death value of the control of	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Deced	lent of Hispanic Origin? (Sperify Cuban, Mexican, Puerto F		ce - American Indian,
US afte urs afte alt, or it control to by Fu	1 XNever Married 2 Married 1 Yes 2XXNo	•		<sub>fy:</sub> White
hour hour	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usua	d Occupation		Business/Industry
21215-00 ed within 72 hou ygjene, and maturi har head naturi t, the Medical I		k done during most of working	ng iss. Kind of S	active and active
21.2 bd with a gigener than the common than th	12 ATM Anal	Lyst	Bank	king
ind be file tal Hy doth event	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Sumar	me)
yla bould I I Men narke natic	Kendall Allen Enslow		Helen Tubekis	
Mar nd 2 sh ulth and 27 Is m			Route Number, City or Town, Laurel, MD 207	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Important: If them 27 is marked other than "natural; or trains 23a or 28a-1 show any injury operations traumatic event, the Marical Experiment and the partitled at once.  To Be Completed by Funeral Director	20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name completely, crematory or of Blair Memorial Completes)	her place) La I Augus	st 24,	- City or Town, State
mit. P partme ontan injur	Tark	d Address of Facility	04 Altoona Funeral Home I	ı. Pennsylvania
Deg English	francis 500 Uni	; J. Collins Liversity Blvd	Funeral Home I ., W., Silver	Inc. Spring, Md 2090:
Sk <sub>2</sub>	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only pnelcause on each line.			Approximate Interval Between
Physician	Immediate Cause (Final disease or condition Metastatic Non-Small Ce			Onset and Death  12 Months
/Medical Examiner	resulting in death)  Due to (or as a consequence of):		u	TI HOHEID
	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
nsit nin	Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury			
60, be executed cian and burial-transit	that initiated events c. Due to (or as a consequence of):			
1 0 18760 cate be e physician; the burit	d			
x 687 certificate ding phys ise as the	IF FEMALE:			
P.O. Box 6 P.O. Box 6 nat the death certifi d by the attending, letached for use as	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pre	egnancy		ite of delivery onth Day Year
O. Bo O. Bo the death in the attenthed for up	1   Yes 2   No 9   Unknown   4   Pregnant at time of death 5   Other (spe	əcify)		onth Day Year
ords, P.O requires that the een signed by the nould be detache	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	ause given in Part I.	23e. Did tobacco use cont	tribute to the cause of death?
d by	Acquired Immune Deficiency Sydrome,	<b>3</b>		3 ☐ Probably 4 ☐Unknown
Record he law requir he has been si			24a. Was an 24b.	Were autoosy findings available
I Record I Record The law requir cate has been s page 2 should Completed	Cytomegalovirus Esophagitis		performed?	Were autopsy findings available prior to completion of cause of death?
ital	25. Was case referred to medical	26. Place of Death		1 ☐ Yes 2 ☐ No
Division of Vita Division of Vita after death. Director: After this certific in by the funeral director. errification: To Be C	examiner? 1 ☐ Yes 2 🛣 No Hospital: 1 🛣 Inpatient 2 ☐ ER/Outpatient 3 ☐ DO	A Other: 4 Nursing Hom	ne 5 Residence 6 Oth	ner (Specity)
ng Pt		8c. Injury at 2: Work?	8d. Describe how injury occur	
Vision Vision Attanding r death. actor: After by the fune	2 Accident investigation M	1 Yes 2 No		
Division of Division of State of Attanding Part of Attanding Part of Attanding Part of State of In by the funers of In by the funers Certification;	4 Homicide  determined  28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office 2	28f. Location (Street and Numb City or Town, State)	per or Rural Route Number,
// # # # # # # # P	29a. Certifier To the best of my knowledge, death occurred a	at the time, date and place, a	nd due to the cause(s) and ma	anner as stated.
o the Hosp thin 24 hou ompletely fil	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.			
To To To Com	29b. Signature and title of certifier 29c.	. License number		d (Month, Day, Year)
	Rejultedin	D43228	August	20, 2004
,	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Lynette H. Posorske 8630 Fenton Street.	#220 5:1	r Chrine Ma 0	00010
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature		r spring, Md 2	0310
Registrar	AUG 24 2004 Some & Span	this		

50	11110111	-	For State	State of M	aryland		artment of H		d Mental Hy	giene	1. 20000
			Registrar  1. Decedent's Name (First, Middle)	Last)	-		timoate or	Dodin	2. Date of De	ath	3. Time of Death
	Physici		Celso E	nrique Me	endez	Esc	calante		August	•	Year 004 13:35 M
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, o	r Location of D		4c. County o	
			Potomac River-10	0800 blk. of	Maca	rthur	Poton	nac		Monto	gomery
	Funeral		5. Social Security Number		ge (In yrs. la	ist birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Bin Min. (Month, Da	th	Birthplace (State or Foreign Country)
	Director		none	ALIWI ZCI F	25	Yrs.			Apr.1	2,1979	Guatemala
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
	Marylan -f show lied at	ţ	MD Montg	omery	Si	lver	Spring				1 ☐ Yes 2 X No
	within 72 hours after death with the Maryland ane. than "natural", or Items 23e or 28a-f show to Madical Examinar court be notified at	Funeral Director	10e. Street and Number 548 Beacon R	oad			10f. Zip Code 20	903		10g. Citizen of WI	_ '
	leath	eral	11. Marital Status	12. Was Decedent	Ever in U.S	i. 13. V	Was Decedent of I	lispanic Origin	? (Specify Yes or No		- American Indian,
(0	riten	F	1 Never Married 2 Marrie	Armed Forces	?		f Yes, specify Cub	an, Mexican, P	uerto Rican, etc.)	Black	, White, etc.
8	al', o	Ď	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1⊠Yes 2□No Guaten			Specify:	White
21215-0036	72 ho	Completed	15. Decedent (Specify only highes	s Education t grade completed)		16a. Deced	dent's Usual Occup kind of work done DO NOT use retire	ation during most of	working	16b. Kind of Bus	iness/Industry
21	within ene. than	ig m	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use retire dscape	d)		Landsc	ape Company
	filed v Hygia other t		17. Father's Name (First, Middle, I	astl				18 Mother's	Name (First, Middle,		
Maryland	2 should be filed v and Mental Hygie is marked other t raumatic event, III	To Be	Manuel Mende						aria Esca		,
lan	2 should and Men is marke		19a. Informant's Name/Relationsh						r Rural Route Numbe		
	1 and 2 Health Jem 27		Carlos Mende	z/Brother	201 71			коаа			Md 20903
Baltimore,	OF = 0.8	9	20a. Method of Disposition 1 ★Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.		Cei	metery, crer	sition (Name of matory or other pla cio San		n 8/31/0	San M	City or Town, State Martin, emala
Balti	permit. Pag Department Important: t any injury o		21. Signature of Funeral Service	will							VICE, P.A. ring, Md20910
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each !	d the death. ine.	Do not ent	er the mode of dyi	ng, such as car	rdiac or respiratory a	rrest,	Approximate Interval Between
	Fnysician	2 1	Immediate Cause (Final disease or condition		Drown	nine.					Onset and Death
	/Medical		resulting in death)	Due to (or as	a conseque	ence o :					
F	Examiner		Sequentially list conditions,	b							
	ad sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease of Flur) that initiated events	Due to (or as	a conseque	ence of):					
_	be executed ician and burial-transit	Examine	that initiated events resulting in death) Last	cDue to (or as	a conseque	ence of):					
8760,	ate be ex hysician the buria	a E									
687	ficate phys s the	edical		d							
Box (	death certificate be executed e attending physician and od for use as the burial-transii	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnan					23d. Date	of delivery
Ď.	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 4 Pregnant a			]Ectopic pregnanc ] Other <i>(specify)</i> _	y 		Mont	h Day Year
0	that the deed by the detached	hys	9 Unknown	9Ll Unknown							
S, P	The law requires that the site has been signed by th bage 2 should be detache	by Р	Part II. Other significant condition	ns contributing to death t	but not resul	lting in the u	nderlying cause giv	ren in Part I.	23e. Did to	N	oute to the cause of death?
ord	v require been si	ed							_ 101	res 2 No 3	3 ☐ Probably 4 ☐ Unknown
Record	has be	ple							24a. Was		ere autopsy findings available ior to completion of cause of
R		Completed							perfo	rmed?   de	ath? XYes 2□ No
Vital	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?						Death (Check only o		
of \	Physic this o	2	Yes 2□ No	Hospital: 1 ☐ Inpati			I JUDON		ng Home 5 Resid		
n	ing P	inol	27. Manner of Death 1 □Natural 5 □ Pending		ay Year)	28b. Time of Injury	Wo	rk?		now injury occurred	d
Sic	Attending or death. ector: After by the fune	icat	2 Accident investig 3 Suicide 6 Could n	ot be age Place of In		7:00	eet, factory, office	Yes 2 No	SUBJECT	a (vivned	r or Rural Route Number,
Division	I or Attendin after death. Director: Aft I in by the fur	Certification:	4  Homicide determine	building, e	tc. (Specify)	)	eet, factory, office		D City or Tov	vn, State)	Or Aural House Number,
_	spitel		29a, Certifier 1 Certifyin	g Physician: To the best		vledge, deatl	occurred at the ti	me, date and p		cause(s) and man	ner as stated
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical		Examiner: On the basis of and manner st	of examination	on and/or in	vestigation, in my	ppinion, death	occurred at the time,	date and place, an	nd due to the cause(s)
	To the Vithin To the Sompi	Me	29b. Signature and title of certifier	,			29c. Licens	se number		29d. Date signed	(Month, Day, Year)
	V		In met 55	croffeell or	<b>3</b>		(	O.C.M.E	•	August	24, 2004
	•	W	30. Name and address of person	who completed cause of	death (Item	23а) (Туре,	Print)		D 31.		1 21201
			Pamela €- South	MII, M.D.					Baltimore,	Marylan	MG 21201
	Sta		31. Date filed (Month, Day, Year)		rar's Signati	ure &	spark	/			
	Regist	ar	AUG 25	2004		/-	/ /				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Audrev Gertrude Ett Aug. 24 2004 8:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9820 Inglemere Drive Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Feb. 20, 1929 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F 75 Yrs. Pennsylvania Director 194-22-0599 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Iteme 23s or 28e-f ehov any injury or other traumatic event, the Medical Examiner mant be modified at Maryland Montgomery 1 ☐ Yes 2X No Bethesda Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9820 Inglemere Drive 20817 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Maritat Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐No White þ Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Callege (1-4or 5+) 1-4 Sr. Executive Secretary Marriott Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cuthbert William Corley Gertrude Margaret Kauffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen H. Ett -husband 9820 Inglemere Drive Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem. 8/27/2004 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Frai Se vice Ciconsee Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature ODC8 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 6 weeks Respiratory Failure resulting in death) /Medical Due to (or as a consequence of) Examiner Lung Cancer 1 year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of): P.O. Box 68760, the attending physician Completed by Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ŏ in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3□ DOA this 28b. Time of Injury in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 XNatural death. М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32610 August 25, 2004 and address of person who completed cause of death (Item 23a) (Type, Print) Thomas J. McNamara, M.D. 10215 Fernwood Rd., #100 Bethesda, Maryland 20817

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 26

32. Registrar's Signature

			1 - For State Registrar	State of Maryla		artmen <i>rtificat</i>			and M		ene	An	1 0	0000
П	Physici	an	Decedent's Name (First, Middle, Last							2. Date of Death Month	Day	Year		e of Death
	/Media		JOHN WILLIAM	ELMORE						August	19	2004	8:1	.8 P <sup>M</sup>
п	Examir	ier	4a. Facility Name (If not institution, give				_	Location of	of Death			nty of Dea		
	Funeral		Laurel Regional  5. Social Security Number 6. S		s. last birthday)	If Under	urel 1 Year	If Under 2	24 Hrs.	8. Date of Birth			George	
	Director			⊠м 2□F 85		Months	Days	Hours	Min.	May 17,	1919	Lei	Lge, M	te or Foreign issour i
	yland how		10a. State 10b. County	10c.	City, Town or Lo	ocation							10d. Inside	e City Limits
	e Ma	ctor	Maryland Montgome	ery S	ilver S	pring							1₺ \	res 2 □ No
	vith th	Directo	10e. Street and Number			10f. Zip				10	g. Citizen o	f What C	ountry?	
	s 23s	erai	1707 Brisbane St		11.0		902		1.0.15		U.S.A			
036	d within 72 hours atter death with the Maryland jiene. rithen "netural", or items 23a or 28e-f show I'ra Medical Exartirat must be notified at	by Funerai	11. Marital Status  1 Never Married 2 A Married  3 Widowed 4 Divorced		1/.2	was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	В	ace - Am lack, Whi cify: Wh:		1,
- - - -	in 72 ho n "netur Nedical	Completed	15. Decedent's Ec (Specify only highest gra	lucation de completed)	16a. Dece	dent's Usua kind of wor DO NOT us	rk done a	lurina most	of worki	ing 1	6b. Kind of	Business	/Industry	
77	d with giene	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 2 Years	Sta	atisti	ica1	Assi	stan	t	Feder	al G	overn	nent
maryland 21215-0036	should be tiled and Mental Hygis s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Yancy Elmore							(First, Middle, M	aiden Sumi	ame)		
_	es 1 and 2 should be of Health and Mental f item 27 is marked r other treumatic ev		19a. Informant's Name/Relationship (7)  Irene T. Elmore/W		19b. Mailir 1707	ng Address B <b>ris</b> l	(Street a	nd Numbe	r or Rura et,	A Route Number,	City or Tow	n, State,	Zip Code) 20902	
garrimore,	ges 1 a		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □	Removal from State	Place of Dispo	natory or ot	ther place						Town, State	
	tment tent:		`4 □ Donation 5 □ Other (Specify	, P	arklawn	Mem.	Par	k 0	8/24	/2004 F	lockvi	11e,	Mary]	Land
e C	permit. Pages 1 Department of H Importent: If ite eny injury or ot once.		21. Signature of Funeral Service Licen	Percenti	ط 11 م	2. Name and INES—F . 800 N	d Addres RINAI New I	s of Facility LDI Fl Hampsh	UNER	AL HOME, Ave, Si	INC.	Spri	ng, MD	20904
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	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):								3 We	
	P *	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):								J WE	EKS
	acuter nd transi	Examine	triat initiated events	c. Pneumonia									2 Day	ys
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200	physicate s	dicai		d. Acute Kella	ı rallu	re								
O. BOX	sicien: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3□	Ectopic pre Other (spe						ate of del	livery Day	Year
cords, P	uires that signed b	by	Part II. Other significant conditions co		esulting in the un	nderlying ca	iuse give	n in Part I.		23e. Did toba			the cause of	_
5	s beer shou	iete	Diabetes							24a. Was an	24h	Were a	itopsy finding	se available
ב	The la te has age 2	Completed								autopsy performe	id?	prior to death?	completion of	cause of
		0	25. Was case referred to medical					26. Place	of Death	(Check only one)		1 🗆 Yes	2□ No	
>	nysici nis ce direc	To B	examiner? 1 ☐ Yes 2 🚰 No	Hospital: 1 💆 Inpatient 2	☐ ER/Outpatieni	t 3 DO/	A Othe			ne 5□Residen		her (Spe	cifv)	
DIVISION OF	Attending Physicien: The lar or death.  ector: After this certificate has by the funeral director, page 2		27. Manner of Death 1 Katural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28 M	Bc. Injury Work 1		2	8d. Describe how				
		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre sify)	eet, factory.	office		2	8f. Location (Stre City or Town,	et and Num State)	ber or Ru	ıral Route Ni	mber,
	To the Hospitel or within 24 hours atternation 24 hours atternation 10 to the Funerel Discompletely filled in	Medicai	29a. Certifier 1 ☐ Certifying Phyone) 2 ☐ Medical Exam	rsician: To the best of my kinder: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred a restigation,	t the time	e, date and inion, death	place, a occurre	nd due to the cau d at the time, date	se(s) and m	anner as , and due	stated, to the cause	o(s)
	To the To the Comp	M	29b. Signature and title of certifier	Ø 77 EF	some		License			29d	. Date sign	ed (Monti	h. Day, Year)	
			Joseph may	OFATER	MAL	P	002	721	6	1	FU G	TZN	70 =	4004
	12		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type, F		SE	(RD	, Ls	LH, LA	NRE	, h	0 20	707
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	1	0.11	,	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month Year **Physician** 21 2004 August 10:06\_A /Medical Jean Miles Elliott 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Olney Olney Year Montgomery

9. Birthplace (State or Foreign 3205 Saint Florence Terrace 8. Date of Birth (Month, Day, Ye May 23, If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Washington, Hours Min. 1928 1**⊈** M 2 □ F 76 Yrs. 578-34-9735 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other then "neturel", or Items 23a or 28e-f show other treumatic event, the Machical Examinar must be notified at Olney Maryland Montgomery 1 ☐ Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ent: If Item 27 is marked other then "neturel", or Items 23a or: USA 3205 St. Florence Terrace 20832 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ X'es 2 □ No If Yes, Give Year or Dates:1946-48 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Heating and Air Elementary/Secondary (0-12) College (1-4or 5+) Conditioning Repair Mechanic 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Be George Elliott Blanche Teresa Morris 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3205 St. Florence Terrace, Olney, MD 20832 Barbara A. Elliott/ Wife August 2004 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 25, Gatery, or material of other place) injuryor 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or 4 □ Donation 5 □ Other (Specify) Cemetery Silver Spring, MD Practice of Collins Funeral 500 University Flvd., W., Home Inc. Silver Spring, MD 20901 21. Signature of Funeral Service Licensee olidations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comolic shock, or heart failure. List only an Immediate Cause (Final **Physician** disease or condition resulting in death) a as hyxiation /Medical Due to (or as a consequence of): Examiner depression Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (biseass) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical as IF FEMALE use If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month ō 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown by, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2√ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1□ Yes 2□No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 70 1 X Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death After 1 Natural 5 Pending 1 🔲 Yes 2 X No death. investigation 2 Accident unkno₩n hanging Director: / Aug 21 2004 unknown | 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Olney 3205 St. Florence Ter., within 24 hours To the Funerel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier atucia August 21, 2004 D51916 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 Montrose Rd., Rockville, Maryland 20852 Patricia Tomsko-Nay, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 25 Registrar

		1 - For State Registrar	State of	Marylan				eaith ar D <i>eath</i>	nd Me	ental Hy	giene Reg. No			0.0.0	r -1
Physici	an.	Decedent's Name (First, Middle, Last	st)						:	2. Date of Do Month	Day		ar	3. Time of	
/Medic	al	Edna Josephine En		ar)		4h City	Town or	Location of I	Death	Augus		, 2004 County of 0		9:55	а м
Examin	er	4e. Facility Name (If not institution, give Washington Adver						Park	Doam			Montgo		v	
Funeral Director		5. Social Security Number 6. S		Age (In yrs. I	ast birthday) O Yrs.		1 Year Days	if Under 24	4 Hrs. [	B. Date of Bi (Month, D	rth ay, Year)	9.	Birthpla	ace (State o	r Foreign
D.		Usual Residence of Decedent		140.00	-										h . 1 (m/h m
arylar ehow	-	10a. State 10b. County			, Town or Loc									xd. In <i>s</i> ide Ci 1 ☐ Yes	
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ture!		3 X Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Date	98:	16a. Deced	ent's Usu	al Occupa	ition			16b. K	ind of Busin			
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be file d oth event	Be	17. Father's Name (First, Middle, Last)								(First, Middle lna Da <sup>.</sup>					
should ind Men inarke umatic	To	Benjamin Frankli			19b Mailin	n Addres	s (Street a	and Number					te. Zio (	Code)	
and 2 s ealth an n 27 is i		Kenneth Swart/ Br						ill Rd							
Hea item		20a. Method of Disposition			lace of Dispos	sition (Na	me of other place			te 28,		ocation - City			
Pages ment of ant: If its		1  Burial 2 □ Cremation 3 □ 1  Other (Specif		Fo	rt Lin Cemete	_			200	)4	Brer	ntwood	M	arvla	nd
permit. Pages 1 and 2 should be filed withir Department of Health and Menial Hygiene. Important: If item 27 is marked other than eny injury or other traumatic event, Ita M. ODGs.		21. Signature of Funeral Service Licer	ISOO Y	10-	22 <b>F</b> r	Name a	nd Addres S J.	s of Facility Colli	ns F	unera				,	
007 € 0		23a. Part1. Enter the disease, or com	Dluc	sed the death				sity B				Spring	M	D 2090 Approximate	
		shock, or heart failure. List only Immediate Cause (Final	one cause on eac	th line.										Interval Bet Onset and I	ween
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the at	/sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnar 9□Unknow	nt at time of de n	eath 5	Other (s	oecify)							,	
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To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funeral Director; After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Example (Check only one)	ysicien: To the b niner: On the bas and manne	is of examina											)
To the To the Complex	Me	29b. Signature and title of certifier	<u>.</u>				c. License	_			_	te signed (N		-	
6		> Steven	TLE				046	998			au	gust.	25,	2000	1
		30. Name and address of person who 34 LS HAM	completed cause	of death (Item	Swte	Print) #/	HYA	tby,	////	MD T. Tex	20 e. M.	7.82		·	
Sta	ate	31. Date filed (Month, Day, Year) AUG 27 20		gistrar's Signa		P		4							

			1 - For State Registrar	State of Marylar	-	artment of He rtificate of D		Mental Hy	giene Reg. No.,	001	
3.4	Physici		1. Decedent's Name (First, Middle, La	st) 1is				2. Date of De Month		Year 2004	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death		1	2004 County of Death	12.50 p.
	LAGIIII	ici	Holy Cross Hos	pital			Spring			20.17	gomery
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth		lace (State or Foreign
ш	Director		579-56-0465	1 <b>X</b> M 2□F 61	Yrs.	Months Days	nours Min.	12-23-			ington, D.
	P .		Usual Residence of Decedent	10- 0	T						
	ahow	<u>_</u>	10a. State 10b. County	10c. Cr	ty, Town or Lo					1	0d. Inside City Limits 1X Yes 2 □ No
	8a-f	Director	D.C.		Was	shington					
	vith c	Dire	10e. Street and Number			10f. Zip Code			_	en of What Cour	ntry?
	s 23g	ra	2422 17th Street,		10 1	200				.S.A.	
96	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f ahow or other traumatic event, the Modical Examinational by notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Decedent of His f Yes, specify Cubar I ☐ Yes 2 🗓 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)	1	4. Race - Americ Black, White, Specify: B1a	etc.
Baltimore, Maryland 21215-0036	tura		15. Decedent's E		16a Decer	ient's Usual Occupa	tion		16h Kin	d of Business/Inc	duetn/
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0	filed Hygie other fent.		17. Father's Name (First, Middle, Last	)			18. Mother's Nam	ne (First, Middle	, Maiden S	Sumame)	
au	ould be t Mental I warked o	To Be	Fredrick Thomas	Ellis			Lilliar	ı Jones	2		
2	2 should be and Mental is marked or raumatic eve	-	19a. Informant's Name/Relationship (		19b. Mailin	ig Address (Street a	nd Number or Ru	ral Route Numb	er City or	Town, State, Zip	Code)
Ž	ith a		Deborah Laushon Ya	ites/Daughter	3201 Silve	Beaverwoo r Spring,	d Lane	.d 2000	16		·
<u>6</u>	Hea Hea tem othe		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place	rial y Lai	Date 2090	20c. Loc	ation - City or To	wn, State
9	ages ant of t: If i		1 🖾 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special	Themoval mom State		Nat'l Cem.		02-04	Tario	mala 17	
	artme artme ortan injur		21. Signature of Funeral Service Lice			. Name and Address				ngle, Vi	
eg M	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra <u>once</u> .		Manda C.	Bacon, CC	361 34	447 14th S	Street,	N.W. Wa	shing	ton, D.	20010
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	th. Do not ente	er the mode of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
١	Physician		Immediate Cause (Final disease or condition	a Acinetobact	er Seps	sis				1	Onset and Death
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X Q	The law requires that the death certifies has been signed by the attending age 2 should be detached for use a.	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	al death 3	Ectopic pregnancy			23	3d. Date of delive Month	ry Day Year
-	e deg	sic	1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time of c 9 ☐ Unknown	death 5	Other (specify)			ŀ	WOTH	Day 16al
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	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	29a. Certifier 1X Certifying PI (Check only one)	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my opi	e, date and place, inion, death occur	and due to the red at the time,	cause(s) a date and p	and manner as standard of the top and due to	ated. the cause(s)
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			Saima	Khowa	12	D00589	065		A11911	st 24, 2	004
	10		30. Name and address of person who				-				
(	K15)		Saima Khawaja			rest Glen	Rd. Si	lver Sp	ring.	Md. 20	910
	Št.	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa							
	Regist		AUC 2 7 200		-						

		1 - For State Registrar	State of Maryland	•	artment of F				4-28669		
Physic √Medi	ical	1. Decedent's Name (First, Middle, Last  Margaret L. Fi	sher					ER 4, Z	dear 3. Time of Death		
Exami	ner	4a. Facility Name (If not institution, give Saint Joseph I	Medical Cent		If Under 1 Year	TOWS	on		altimore		
Funeral Director		5. Social Security Number 6. Se 216-24-0969 10 Usuel Residence of Decedent	7. Age (In yrs. I. ☐ M 2⊠F 77	Yrs.	Months Days	Hours Min.	(Month, Day	Year) 4,1927	n. Birthplace (State or Foreign Country) Maryland		
Maryland a-f show	tor	10a. State 10b. County  MD Harford		nite I					10d. Inside City Limits 1 ☐ Yes 2√2 No		
n with the	i Direc	10e, Street and Number 5332 Norrisvi.	lle Road		10f. Zip Code 2116	1		10g. Citizen of Wh	at Country?		
yland 21215-0036  build be filled within 72 hours after death with the Maryland Mental Hygiene.  arked other then "natural", or Items 23a or 28a-f show atto event, the Medical Exertine must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	į.	Was Decedent of H f Yes, specify Cubin 1 ☐ Yes 2 X No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Black,	American Indian, White, etc. White		
21215-0036 d within 72 hours af giene. ar than "natural", or the Medical Exert	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's U (Give kind of life, DO NO					16b. Kind of Busin			
Iryland 212 should be filed within ad Mental Hygiene. marked other than	To Be Co	12 17. Father's Name (First, Middle, Last) Wilbur Brown		ne (First, Middle, Hofmei	Own H	Ottle					
Aar 2 sh and is m	-	19a. Informant's Name/Relationship (T) John Fisher/Sor			-	and Number or Ru	ral Route Numbe	r, City or Town, St	ate, Zip Code) , PA 17302		
Heal Heal		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	20b. Pl	lace of Dispo	sition (Name of natory or other plac	ce) Sept	Date 9,	20c. Location - Ci	ty or Town, State		
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe once.		4 ☐ Donation → ☐ Other (Specify, 21. Signature of Purieral Service Licent		22	. Name and Addre	U •	J. Har	tenstei	Maryland n Mortuary,		
15		23a. Partyl. Enter the disease, or comp strock, by heart failure. List only of	dications that caused the death						PA 17363  Approximate Interval Between Onset and Death		
Physician /Medical		Immedate Cause (Final disease or condition resulting in death)	aCONGESTIVE		RT FAIL	URE					
Examiner	ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	ARD I OMY OP ATHY Due to (or as a consequence of):							
Hecords, P.O. Box 68/60,  The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. CORONARY A Due to (or as a consequ		Y DISEA	5E					
Box 68, eath certificate attending phy for use as the	/Medic	IF FEMALE:	23c. If yes, outcome of pregnar	ncv				23d. Date of	of delivery		
b.O. BOX  at the death cert by the attendin tached for use	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month			
ecords, P. law requires that as been signed b	b	Part II. Other significant conditions co	entributing to death but not resu	ulting in the u	nderlying cause giv	ren in Part I.		iid tobacco use contribute to the cause of death?			
	Completed						24a. Was a autops perfore 1 Yes	sy prio	re autopsy findings available r to completion of cause of th? Yes 2 \( \sigma \) No		
VITA! H sician: The certificate h rector, page	Be	25. Was case referred to medical examiner?	Hospital:	50/0	Oth	OF.	th (Check only on				
DIVISION Of VITA with the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ation; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ER/Outpatien 28b. Time of Injury	28c. Injur Wor	4   Nursing H		ence 6 Other own injury occurred	(Specify)		
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Si City or Town	treet and Number on, State)	or Rural Route Number,		
DIV To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Medical (	29a. Certifier 1 Certifying Phy (Check only one)	vsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death lion and/or inv	occurred at the tir restigation, in my o	me, date and place, pinion, death occur	and due to the cred at the time, d	ause(s) and mann ate and place, and	er as stated. I due to the cause(s)		
To th withir To th comp	Me	29b. Signature and title of certifier	mella m.	C	29c. Licens	e number		9d. Date signed (	Month, Day, Year)		
3		30. Name and address of person who c			Print)						
St Regist	ate trar	31 Date filed (Month Day Year)	32. Regular's Signat	7.6.71 1 ture	SLER D	RIVE, TO	JWSON,	MARYLAN	ID 21204		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yeer **Physician** Clifford L. Flanagan Sept 2004 5:30 A /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Lions Manor Nursing Home Cumberland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthpian (Month, Day, Year) 9. Birthpian Country Oct 13,1912West 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1⊠M 2□F 9 1 Yrs. Director 220-24-0781 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-1 show any injury or other treumatic event, the Modical Examiner must be multiled an once. 1XYes 2 No Maryland Allegany Cumberland Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1 Baltimore Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give WW II Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retired Navy 12 Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clifford Price Flanagan Lossie Dale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jimmie D. Flanagan-Brother 10409 Witt Lane, LaVale, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept 20c. Location - City or Town, State 1 ☐ Burial 2 TCremation 3 ☐ Removal from State Silbaugh Crematory 8,2004 A □ Donation 5 □ Other (Specify) Uniontown, PA 15401 22. Name and Address of Facility Hafer Funeral 21. Systure of Funeral Service Licensee Service, PA 1302 National Hwy, LaVale, MD 21562 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Bil nemme wend Physician 2- needs /Medical Examiner Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto (or as a nonsequence of): the attending physician and hed for use as the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 page 2 should be Byten 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Caknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 5 24a. Was an has autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending after death.

I Director: Af 1 Tyes 2 □ No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D21240 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FIVA 31. Date filed (Month, Day, Year) 32. Registi

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year August 18, Mary Agnes Folks 2004 7:55p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2302 Seminole Street Adelphi Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🙀 F Yrs. Director 219-36-8073 81 Feb. 24, 1923 England Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Adelphi 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2302 Seminole Street 20783 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 23€ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2€ No Specify:White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Eye Technician Health Care permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury of other treumetic event ADRS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Frederick Martin Charlot Newing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7718 Finns Lane, Lanham, MD 20706 Bill L. Yoho/ Personal Rep 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State August 25 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan <sup>4</sup> □ Donation 5 □ Other (Specify) Crematory 2004 Alexandria, Virginia 21. Signatur of Free al Service Linense 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. over 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Coronary Artery Disease Years /Medical Due to (or as a consequence of): Depressed Left Ventricular Function Sequentially list conditions, any, leading to initialists cause. Enter Underlying Cause (Disease or injury Years Examiner Dualto (or se a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Chronic Obstructive Pulmonary Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Paroxysmal Ventricular Tachycardia autopsy performed? 1 Yes 2 No 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760 Records, P.O. signed by I Division of Vital the Hospital or Attending Physician: After thi funeral Certification: death. Director: To the Hospital within 24 hours a To the Funeral E

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or Items 23e

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Baltimore, Maryland 21215-0036

investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

30. Name and address of person who completed cause of te th (Item \* a) (Type, Print) 10313 Georgia Avenue, Silver Spring, MD 20902 Herman Segal, M.D.

Registrar

31. Date filed (Month, Day, Year) AUG 25 2004 32. Registrar's Signature

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		•	1 - State Registrar			rtificate o		,	leg. No. 2001	28672
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ith the	or 28	Director	10e. Street and Number			10f. Zip Code	)		10g. Citizen of What C	ountry?
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/lan uld be Mental	marked matic ev	To B	ALBERT FONOROFF				MILDR	ED GOLDST	EIN	
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C, N 1 and Health	em 27 ther ti	-	ANDREW M. FONOROI  20a. Method of Disposition	F - BROTH	The second second			G, CUMMIN	G, GEORGIA	
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Geath	of for u	clar	in the past 12 months?	1 ☐ Live birth : 4 ☐ Pregnant at		∃Ectopic pregnan ∃ Other <i>(specify)</i>			Month	Day Year
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he Ho	he Fu	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner stat	examination and/or in	vestigation, in my	opinion, death occ	curred at the time, d	ate and place, and due	to the cause(s)
Tot	To 1 com		29b. Signature and title of certifier			29c. Licer	nse number	2	9d. Date signed (Mont	h, Dey, Year)
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			Decedent's Name (First, Middle, Last	st)							2. Date of Dea	ath		3. Time of Dea	th
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	/Medi Examir		4a. Facility Name (If not institution, give				4b. City, To	wn, or L	ocation o		.100001	4c. County of Death			
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	Funeral		5. Social Security Number 6. S	өх	7. Age (In yrs. la	st birthday)	If Under 1	Year	If Under 2		8. Date of Birt	h		thplace (State or For puntry)	eign
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Maryland	2 sh and is m		19a. Informant's Name/Relationship (7				•						or Town, State, 2		
	and ealth m 27		MARILYN M. DAVIS	- NIECE		3412	ALABAM	IA A	VENUE				VIRGINI		
ore	S E E E	1	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 🖔	Removal from :		ice of Dispo metery, crei	sition (Name natory or othe	of er place)		D	ate	20c. L	ocation - City or	Town, State	
<u>Ē</u>	Pag ment ent: I		`4 □Donation 5 □ Other (Specify		KINO	G DAVI	D MEM.	GAI	RDEN	8/20	/2004	FA]	LLS CHUR	CH, VIRGI	NI
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: If item 27 is marked other then 'neturn any injury or other treumatic event, the Medical Once.		21. Signature of Funeral Service Licen	See .		22	Name and A	Address	of Facility	ED C A	AEMOD T A 1		TABELO	THE	
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that can	aused the death.	Do not ent	er the mode o	of dying,	such as c	ardiac of	respiratory arr	est,	,	Approximate Interval Between	
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7	/Medical		disease or condition resulting in death)	a	Or as a conseque		N	NE	LLM	0 1/1	Π				
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Records,	sign sign d be	d by					, ,	J			1 T	i i	. I	obably 4 Unkno	
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€C	The law ate has I page 2 s	ldu									24a. Was a autops	y	prior to c	topsy findings availa completion of cause	ble of
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of Vital	Attending Physicien: Threads	Be	25. Was case referred to medical examiner?	11						of Death	(Check only on	e)			
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п	ding P	:ua	27. Manner of Jeath Natural 5 Pending	28a. Date of	of Injury h, Day Year)	8b. Time of Injury	28c.	Injury at Work?	t	2	Bd. Describe ho	ow inju	ry occurred		
0	endi sath. or: A he tu	ati	2 Accident investigation				М	1 🗌 Ye	s 2 🗆 N	0					
Division	er der rect	ţį.	3 Suicide 6 Could not be determined	289. Place	of Injury - At hom	e, farm, str	eet, factory, of	ffice	100	2	Bf. Location (St City or Town	reet ar	nd Number or Ru	ral Route Number,	
Q	rs afte	Certification;											,		
	Hospitel		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the	best of my knowl	edge, death	occurred at t	he time,	date and	place, a	nd due to the ca	ause(s)	and manner as	stated.	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely tilled in by the ti	edical	one)	and mann	ner stated.	m and of IA	resugation, in	my opin	non, death	OCCUTTO	at tile time, d	ate and	place, and due	to the cause(s)	
	To the comp	ž	29b. Signature and title of certifier		', N	ຄ		icense n		,	2	9d. Da	te signed (Month	, Day, Year)	
	3		Heparage	me-	7 17.	ע.		- 2·		60		8	17/04		
	2		30. Name and address of person who co	ompleted cause	e of death (Item 2	23a) (Type,	Print)	1		0::::			115		
				MAMI		11119	ROCK	UIL	LE.	F 114	1 Kocy	40	20850	2	
	Sta	te	31. Date filed (Month, Day, Year)	32. R	gistrar's Signatu	гө 🛵	1.	1	,		<u> </u>	-			
	Registr	ar	ALIG 2.3 20	104	eneva	D	spon	ROS			1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Mary Cantu Flaherty August 28, 2004 РМ 2:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mechanics ville 38516 Betyn Lane St. Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. March 1, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex Birthplace (State or Foreign Country) 1 □ M 2 X F Yrs. 1920 Texas Director 578-32-5963 84 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic ayant, the Medical Examiners ust be notified at 1 ☐ Yes X ☐ No Director Maryland St. Mary's Mechanicsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or itams 23e 38516 Betyn Lane 20659 USA death 1 Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status be filed within 72 hours after de ital Hygiene. id othar than "natural", or Itam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil ment of Health and Mental H lent: If itam 27 is markad oth Be Isidoro Cantu Delfina Blanco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick E. Flaherty - Son 8985 Mackall Road, St. Leonard, MD 20685 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department of Importent: If any injury or once. MD Veterans' Cemetery 9-11-04 Cheltenham, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Ineral Service Licensee M01391 Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as or injury) Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown s been signed by the should be detached Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 1 No 2 No 1 Yes 1 Tyes To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Alatural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funaral Diractor: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Box 68760

Division of Vital Records, P.O.

State Registrar

DHMH 17 Rev 1/2001

Dr. William D. Boyd, AUG 3 1 2004 31. Date filed (Month.

30. Name and address of pirson who complined cause of death (Item 23a) (Type, Print)

25365 Point Lookout Road, Leonardtown, MD 20650 32. Resistrar's Signature S. Marie

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		1 - State Registra MEND#23e&24apo	enME8/25/04,BMW,I	v <sub>bCb</sub> Ce	rtificate	of Death	7	!	Reg. No.		2007
		1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea	ath — Day	Year	3. Time of Dea
hysici: /Medic		Patricia Ann G	riffiths					AUG.	20, 2	2004	0100 A
xamin		4a. Facility Name (If not institution, give	street and number)		4b. City, Tox	wn, or Location	of Death		4c. Co	unty of Death	
		5721 GROSVENOR L	ANE-MARINER H	IEALTH	BET	HESDA			MON	TGOMER	RΥ
neral		Social Security Number     6. Security Number	ex 7. Age (In yi	s. last birthday)	If Under 1 Y	Year If Unde Days Hours	r 24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birthp	place (State or For
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		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	ocation			-			10d. Inside City Li
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De D	ă	10e. Street and Number			10f. Zip Co				iog. Citizen	of What Cour	ntry?
8 23	rai	17643 Kohlhoss		110		0837		7 1/	14	USA	and testing
Important; if item 27 is marked other than "natural", or items 24s or 28s-1 show any Injury or other traumatic event, the Modical Examinar must be notified at once.	1/643 KONTHOSS ROAD   20837							ecity Yes or No- Rican, etc.)		Race - American Indian, Black, White, etc. Decify: White	
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rked tic e	To B	Donald Francis	Quigley			Ma	axine	Kay Bal	lew		
E TA	-	19a. Informant's Name/Relationship (7	Type, Print)	19b. Maili	ng Address (S	Street and Num	ber or Rura	il Route Numbe	er, City or To	wn, State, Zip	Code)
r tra		Jeffrey Griffith	s/ Husband	1764	3 Kohl	hoss Ro	1. P	oolesvi	lle. N	4D 2083	37
를 함		20a. Method of Disposition		. Place of Dispo	osition (Name	of !		Date	-	on - City or To	
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			23a. Part1. Enter the disease, or comp	lications that caused th	e death. D	Do not ent	D3_WStc er the mode of dvir	ocktor	Street	ratory arre	cton, M	lary1	and 21921 Approximate	
			shock, or heart failure. List only o	ne cause on each line	1		,						Interval Between Onset and Death	
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	HINA		30. Name and address of person who co Michael Alber	ompleted cause of dea	ith (Item 23	a) (Type,	Print) ene Sta	eet	Baltim	ore, M	10 2	120		
	Sta Registi		31. Date filed (Month, Day, Year)  SFP 0 9 20	32. Fagistrar										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3, Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician AUGUST** GEISBERT 21 2004 9:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 501 B S. Frederick Avenue, #1 Gaithersburg Montgomery 8. Date of Birth (Month, Day, Year) Oct. 29 1932 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 177 26 6347 156 M 2□F Vrs Director Maryland Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be inclined at Gaithersburg Md. Montgomery 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 B S. Frederick Avenue, #1 20877 United States death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itel mportant: If item 27 Is marked other than "natural", or Itel any injury or other traumatic event, the Medical Examina 1 Styes 2 No
If Yes, Give
Year or Dates: Korean 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Allen Geisbert, Sr. lena Lenhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 B S. Frederick Ave., #1, Martha E. Geisbert / Wife Gaithersburg, Md.20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Parklawn Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 8/25/04 Rockville, Md. 22 Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Şervice Licensee muriy H. Buker P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 9 YEARS METASTATIC COLON CANCER /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After t 5 Pending investigation 1 X Natural after death. М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a, Certifier 🔣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified August 23, 2004 341 MD060375 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 PRINCE PHILIP DR., #327, PAUL A. BANNEN, M.D. OLNEY, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature sach AUG 24 Registrar 2004

Registrar

State

31. Date filed (Month, Day, Year) AUG 25 2004

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

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RAMAN R. TULI,

3503 PERRY ST., SUITE B, MT. RAINIER, MD. 20712 32. Begistrar's Signature rakes

29c. License number

960

29d. Date signed (Month, Day, Year)

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Exam.	iiiei	Washington Count				Hagers			shington	1
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or 28e-f	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Country?	
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ital Hygiene. d other then "netural", or items 23e or 28e-f show event, tre Medical Exertified must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 No. If Yes, Give Year or Dates:	,	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 → No	lispanic Origin? (5 an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		ce - American Inck, White, etc.  Y: White	
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penint. rages I and should be light with Department of Health and Mental Hygiene. Importent: If item 27 is marked other then any Injury or other treumatic event, Ire. Mone.	To Be	17. Father's Name (First, Middle, Las Victor P. Buhr	man				me (First, Middle, M G. Flair	Maiden Surnan	ne)	
h and rism treum		19a. Informant's Name/Relationship			_		ural Route Number,			'
Healt em 2		Sheridan G. Glad 20a. Method of Disposition	nlii (Husba	.nd) Z1128 20b. Place of Dispo	Jefferso	n Blvd.			yland 2 City or Town, S	
ayes intof i: if it		1 Burial 2 □ Cremation 3 [		Blue Ridge	natory or other plac		8/26/2004			
artme orteni Injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	• •				borne Fur			-
lmp any one		100.1-	1				Williams <sub>I</sub>			
\$		27a. Part1 Enter the disease, or con	iplications that caused t	1.101						oximate
ured J Insit	2				uence of):					
	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	rue to (or as a conseque to (or as a conseque to (or as a consequent)	uence of):					
70.00	edical	Cause (Disease or injury that initiated events	C		uence of):					
ettending for use es	edical	Cause (Disease or injury that initiated events	c	ue to (or as a consequ	uence of):	en in Part I.	23b. Did tot	pecco use con	ntribute to the c	euse of deetl
by the ettending tached for use ex	Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	ue to (or as a consequ	uence of):	en in Part I.			ntribute to the o	
us been signed by the ettending 2 should be detached for use es	by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	ue to (or as a consequ	uence of):	en in Part I.		s 2 No	3 ☐ Probably  24b. Were au available	4 XUnkno topsy findings
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s certificate has been signed by the ettending director, page 2 should be detached for use es	To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significent conditions of the co	cD  d contributing to death but	ue to (or as a consequence to form as a consequence not resulting in the unit of the consequence to a conseq	uence of):  uence of):  inderlying cause give	26. Piace of Dea er: 4⊡ Nursing H	1  Ye  24a. Was en perform  1 Ye  ath (Check only one)	autopsy ed?  s 2 √ No  s 2 √ No  c 6 □Othe	3 Probably  24b. Were au available completi of death?  1 Yes	4 XUnknotopsy findings prior to on of cause
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n. After this certificate has been signed by the ettending funeral director, page 2 should be detached for use es	To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significent conditions of examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 2 XAccident investigation 3 Suicide 6 Could not be	d	not resulting in the un	uence of):  uence of):  iderlying cause give  iderlying cause give  iderlying cause give  iderlying cause give  iderlying cause give  iderlying cause give	26. Piace of Dea er: 4⊡ Nursing H	1 Ve  24a. Was en perform  1 Ve:  ath (Check only one ome 5 Resider 28d. Describe how Patient another	autopsy led?  s 2 No  s 2 No  s)  noce 6 Othe winjury occurr Was re vehicl	3 Probably  24b. Were au available completi of death?  1 Yes  er (Specify) ed ar ende	4 EXUnknoon topsy findings prior to on of cause 2 No d by
n. After this certificate has been signed by the ettending funeral director, page 2 should be detached for use es	To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significent conditions of the co	d	not resulting in the understand the second s	uence of):  uence of):  aderlying cause give  t 3 DOA Othe 28c. Injury Work M I No	26. Place of Dea er: 4 □ Nursing H at ?? res 2 □ No	1 Ve  24a. Was en perform  1 Ve:  th (Check only one one 5 Resider  28d. Describe how Patient another  28f. Location (Str. City or Town,	a autopsy led?  s 2 No  s 2 No  s)  nce 6 Other w injury occurr Was re vehic1 eet and Numbe State)	24b. Were au available completi of death?  1 \( \text{Yes} \)  er (Specify)  ed  ear ende  e  er or Rural Rout	4 ⊠Unknor  topsy findings prior to on of cause?  2□ No  d by
4 hours efter death. Funerel Director: After this certificate has been signed by the ettending tely filled in by the funeral director, page 2 should be detached for use ex	Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significent conditions of examiner?  1  Yes 2 No  27. Manner of Death 1  Natural investigation 3  Suicide 4 Homicide  Part II. Other significent conditions of the examiner?  1  Yes 2 No  27. Manner of Death 1  Natural investigation of the examined determined determined.	d	not resulting in the un  t 2 ER/Outpatient 28b. Time of Injury 200 4 y - At home, farm, stre (Specify) of her ho my knowledge, death xamination end/or inv	uence of):  uence of):  uence of):  derlying cause give  28c. Injury Work  M 1 1 2  oet, factory, office  ome— drive occurred at the tim	26. Place of Dea ar: 4 □ Nursing H rat r? Yes 2 □ No ⊇Way e, date and place	1 Ve  24a. Was en perform  1 Ve:  ath (Check only one  ome 5 Resider  28d. Describe hov  Patient  another  28f. Location (Str. City or Town,  Jefferso	autopsy led?  s 2 No  noe 6 Other winjury occurr was re vehicl seet and Number State)  on Blvd	24b. Were au available completi of death?  1  Yes  er (Specify) ed ear ende e er or Rural Rout . Smith	4 ⊠Unknow  topsy findings prior to on of cause  2□ No  d by e Number, sburg,
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nosprial or Atentuing Prostcient: The Taw requires that the death certificate hours either death.  4 hours either death.  5 hours either death.  6 hours either eit	edical Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significent conditions of the examiner?  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation investigation investigation determined.  2 Accident 3 Suicide 6 Could not be determined.	d	not resulting in the un  t 2 ER/Outpatient 28b. Time of Injury 200 4 y - At home, farm, stre (Specify) of her ho my knowledge, death xamination end/or inv	uence of):  uence of):  uence of):  derlying cause give  28c. Injury Work M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	26. Place of Dea  at ??  Yes 2 □No  EWay e, date and place inion, death occur e number	1 Ve  24a. Was en perform  1 Ve:  ath (Check only one  ome 5 Resider  28d. Describe hov  Patient  another  28f. Location (Str. City or Town,  Jefferso , and due to the cau  rred at the time, dal	a autopsy led?  s 2 No  n autopsy led?  s 2 No  o)  nce 6 Other  winjury occurr  was re  vehicl set and Number  State)  on Blvd use(s) and ma te and place, a	24b. Were au available completi of death?  1  Yes  er (Specify) ed ar ende er or Rural Rout  Smith nner as stated. and due to the ca	4 □XUnknoon  topsy findings prior to point of cause of the cause of t
ang rhystolen: The law requires that the death certificate that been signed by the ettending funeral director, page 2 should be detached for use ex	edical Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significent conditions of the examiner?  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation investigation investigation determined.  2 Accident 3 Suicide 6 Could not be determined.	Hospital: 1 Impatient 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. in front nysician: To the best of miner: On the basis of e and manner state	not resulting in the understand the second s	uence of):  uence of):  uence of):  derlying cause give  28c. Injury Work 1   0  oet, factory, office  ome— drive occurred at the tim estigation, in my op  29c. License  D0011	26. Place of Dea  at ??  Yes 2 □No  EWay e, date and place inion, death occur e number	1 Ve  24a. Was en perform  1 Ve:  ath (Check only one  ome 5 Resider  28d. Describe hov  Patient  another  28f. Location (Str. City or Town,  Jefferso , and due to the cau  rred at the time, dal	a autopsy led?  s 2 No  n autopsy led?  s 2 No  o)  nce 6 Other  winjury occurr  was re  vehicl set and Number  State)  on Blvd use(s) and ma te and place, a	24b. Were au available completi of death?  1  Yes  er (Specify) ed ear ende er or Rural Rout . Smith nner as stated. and due to the cr	4 □XUnkno  topsy findings prior to on of cause  2□ No  d by e Number, sburg, ause(s)

. 101	partment of Health and Me	ntal Hygiene
1 - State Registrar Ce	ertificate of Death	Reg. No. 0 0 1 0 0 0 0 0
1. Decedent's Name (First, Middle, Last)	2	Date of Death  Month  Day  Year  3. Time of Death
Physician /Medical Lenora Virginia Gladwin		August 28, 2004 6:58 A M
Examiner 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Homewood Retirement Center	Williamsport	Washington
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda.	y) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Date of Birth (Month, Day, Year)  9. Birthplace (State or Foreign Country)
220–30–9866 90 mm		Jan. 9, 1914 West Virginia
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
or I sho		1 ☐ Yes 2 🕍 No
Maryland Washington Hagersto	OWN 10f. Zip Code	10g. Citizen of What Country?
10.40 Durantida A	21740	USA
10a. State 10b. County 10c. City, Town or Mary land Washington Hagerston 10c. City, Town or 10c. City, Town		
Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	<ol> <li>Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Rice</li> </ol>	can, etc.) Black, White, etc.
Midowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	Specify: White
15. Decedent's Education (Specify only highest grade completed)  16a. Dec (Givernment and Specify only highest grade completed)  16b. Decedent's Education (Givernment and Specify only highest grade completed)  16c. Decedent's Education (Givernment and Specify only highest grade completed)  16d. Decedent's Education (Givernment and Specify only highest grade completed)  16d. Decedent's Education (Givernment and Specify only highest grade completed)  16d. Decedent's Education (Givernment and Specify only highest grade completed)  16d. Decedent's Education (Givernment and Specify only highest grade completed)  16d. Decedent's Education (Givernment and Specify only highest grade completed)  16d. Decedent's Education (Givernment and Specify only highest grade completed)  16d. Decedent's Education (Givernment and Specify only highest grade completed)  16d. Decedent's Education (Givernment and Specify only highest grade completed)  16d. Decedent's Education (Givernment and Specify only highest grade completed)  16d. Decedent's Education (Givernment and Specify only highest grade completed)  16d. Decedent's Education (Givernment and Specify only highest grade completed)	cedent's Usual Occupation	16b Kind of Business/Industry
(Gingle Specify only highest grade completed)  (Gingle Specify only highest grade completed)  (Gingle Specify only highest grade completed)  (Gingle Specify only highest grade completed)  (Gingle Specify only highest grade completed)	ve kind of work done during most of working i. DO NOT use retired)	
College (1-4or 5+)	retary	Religion
Tr. Father's Name (First, Middle, Last)	18. Mother's Name (A	First, Middle, Maiden Sumame)
Tr. Father's Name (First, Middle, Last)  17. Father's Name (First, Middle, Last)  John Scott Lantz	Stella	Twyford
19a. Informant's Name/Relationship (Type, Print)	iling Address (Street and Number or Rural F	Route Number, City or Town, State, Zip Code)
James T. Gladwin/Son 1157	74 Popes Head View La	ane Fairfax,VA 22030
20a. Method of Disposition 20b. Place of Disposition 1 Burial 2 Cremation 3 Removal from State	position (Name of Date rematory or other place)	e 20c. Location - City or Town, State
E d d d d d d d d d d d d d d d d d d d	urg Crematory 08-29-2	2004 Smithsburg,Maryland
Topo and the part of the part	22. Name and Address of Facility	rne Funeral Home,P.A.
m as is a line of the second	125 S.Conococheague	St. Williamsport,MD 21795
23a. Pert1. Ever the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or r	espiratory arrest, Approximate Interval Between
Immediate Cause (Final disease or condition Compatible	Heart Failon with A	lestifut Insulling Onset and Death
	17000	1 minth
Examiner  Sequentially list conditions, francy, badding to manufacture cause. Enter Underlying Cause. Disease or influence of influence or influence		
Sequentially list conditions, if any, leading to manufacts cause. Enter Underlying Cause (Disease or injury		
19 10 10 10 10 10 10 10 10 10 10 10 10 10		
resulting in death) Last Due to (or as a consequence of):		
68760, fileate be en physician is the burial at the burial edical E.		
S S S S S S S S S S S S S S S S S S S		
The state of the s	3 □Ectopic pregnancy	23d. Date of delivery
in the past 12 months?    The late of the	5 ☐ Other (specify)	Month Day Year
TF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1		
Becords, the state of the state	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
av requires as been signe 22 should be as been signe (Conspirators) and pletted by pletted by a chistoff of the conspirators o		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown
Censboroson episode enb	slic	24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
2) C 2 5 5 5		performed?   death? 1   Yes 2   No   1   Yes 2   No
25. Was case referred to medical examiner:  1	26. Place of Death (0	Check only one)
25. Was case referred to medical examiner?    Continue of the continue of the	ient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manper of Death 27. Manual 5 Pending 28a. Date of Injury (Month, Day Year) Injury Injury		d. Describe how injury occurred
27. Manoer of Death   Solution	M 1 ☐ Yes 2 ☐ No	
3 ☐ Suicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f	f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only 2) Medical Examiner: On the basis of examination and/or		
29a. Certifier 11 Certifying Physician: To the best of my knowledge, de (Check only (Check only 2) Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, and	d due to the cause(s) and manner as stated.
gifting and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
R. L. Effer MD	20026579	8/28/04
30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	4. 4
30. Name and address of person who completed cause of death (Item 23a) (Typ  R.C. (Cycle MD 747 NovAHE)	IN AVE ISAGEASTI	OWN MARYLAND
State 31. Date filed (Month, Day Year) 32. Bigistrar's Signature	1 4.	

			1 - State of Maryland / Dep	artment of Health and M	fental Hygiei	0001	00001
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer	3. Time of Death 2:15 M
	/Medic	al	Jean Marie Hornbaker  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	August 29	9, 2004 4c. County of De	
	Examin	er	11450 Rockhill Road	Hagerstown		Washin	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Ye	9. Bi	irthplace (State or Foreign Country)
	Director		217-56-1400 1 M 2 XF 55 Yrs.	Monard Bayo House Minn	June 30,		ryland
	and ow	}	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Many Fied a	tor	Maryland Washington Hagerst	own			1 ☐ Yes 2 X No
	h the or 28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What C	Country?
	23a c		11450 Rockhill Road	21740		USA	
	ar dez	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show fra Modical Examinat must be notified at	by F	1 □ Never Married 2 🕅 Married 1 □ Yes 2 🖺 No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: W	hite
21215-0036	2 hou	ted		edent's Usual Occupation	16b	, Kind of Busines	s/Industry
21,5	ithin 7 19.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ing		
2	led wi lygien her th		12 Home	emaker	e (First, Middle, Maid	Domesti	С
anc	d be fi	Be	George H. Linder		arie Strai	,	
Maryland	should hd Me mark matic	ဥ		ing Address (Street and Number or Rura			Zip Code)
	nd 2 salth ar 27 is r trau		Gary N. Hornbaker/Husband 1145	0 Rockhill Road, 1	Hagerstown	n, Md.	21740
ore,	of Head		20a Method of Disposition 20b. Place of Disp			Location - City o	r Town, State
Ĕ	Pagement ment: ant: it ury o		`4 □Donation 5 □Other (Specify) Rest Hav	en Cemetery 9/2/2			, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, if a Medical Examinat must be mulliad at once.			2. Name and Address of Facility Res 1601 Pennsylvania A			
8760,	icate be executed /Medical Examiner bhysician and street s	dicai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ter the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between Onset and Death
P.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Mec		□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	elivery Day Year
	es tha igned l	by P	Part II. Other significant conditions contributing to death but not resulting in the			V	to the cause of death?
ord	w requires to been signer should be	ted	1280un merasi	0(5) 5	1 Tes		Probably 4 Unknown
Rec	The law ate has b bage 2 sl	Completed			24a. Was an autopsy performed	death?	autopsy findings available completion of cause of
/ita	cian: entifica ector, I	Be	25. Was case referred to medical examiner?		(Check only one)		
<del>_</del>	Physician: r this certific ral director,	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		me 5 sidence 28d. Describe how in		ecify)
O	ding l h. After funer	tion	1 → Natural 5 □ Pending (Month, Day Year) Injury	Work? M 1 □ Yes 2 □ No	200. Describe now ii	ijary occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street City or Town, St		Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea (Check only one) Medicel Exeminer: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a tvestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	o(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier	29c. License number	29d. (	Date signed (Mon	th, Day, Year)
	6		Mud Mandan	D464	13/	tugus	t 30,200 H
5	410		30. Name and address of person who completed cause of death (Item 23a) (Type	1130 OPAL	CT . +	lagers	town, MD
	Sta Registr		31! Date filed (Month, Day, Year) 1 2004 32. Abgistrar's Signature	och	, .		21740

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Sep 4, 2004 Harper 1:30 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany Cumberland Nursing Center Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 8, 1927 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1₩ M 2□ F Days MD Yrs. Director 212-24-0580 76 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If item 27 Is marked other then "neture!", or items 23a or 28e-f show any injury or other treumstic event, The Medical Examinet insut to notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Cumberland MD Allegany Completed by Funeral Director 1 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 504 Fourth Street 21502 USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 owner/operator B/Burn Trucking Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Boyd Harper P Nyanza Belle Biser Harper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 538 Earl Harper son Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hillcrest Memorial Park 9/7/2004 4 ☐ Donation 5 ☐ Other (Specify) Cumberland MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Physician Erstral basunhoge /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examine or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (u. as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? Parlintson's di 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ģ Completed 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ Certification: 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Watural
2 Accident 5 ☐ Pending investigation To the Hospitel or Attending within 24 hours after death.

To the Funerel Director: After completely filled in by the fur 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TyCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) 1.0 31. Date filed (Month State Registrar

DHMH 16 Rev 6/95

		State of Maryland / Depart State of Maryland / Depart Cert	rtment of Health and Me tificate of Death		ene g. n. 2, 004 2, 8683
Physicia		Decedent's Name (First, Middle, Last)     HENRY HOLDEN HUGHES		2. Date of Death Month EPI EMISER	Day Year
/Medica			4b. City, Town, or Location of Death WESTMINSTER	OF FEMILER	4c. County of Death  CARROLL
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 214–28–0747 1 ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑	Months Days Hours Min.	B. Date of Birth (Month, Day, 1 APRIL 10	9. Birthplace (State or Foreign Country) TENNESSEE
land ow		Usual Residence of Decedent         10c. City, Town or Loc.           10a. State         10b. County         10c. City, Town or Loc.	ation		10d. Inside City Limits
ne Mary 8a-f sh	Director	MARYLAND CARROLL WESTMINST			1 ☐ Yes 2 ☐ No
h with th	al Dire	10e. Street and Number 1934 OLD BACHMAN VALLEY ROAD	10f. Zip Code 21158		g. Citizen of What Country? JNITED STATES
ore, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland at Health and Mental Hygiene. item 27 is marked other than "natural; or frams 23a or 28a-f show other traumatic event, the Medical Exercities rast by notified at	by Funeral	1 ☐ Never Married 2 2 Married 1 ☐ Yes 2 No		ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE
72 hours adject to		(Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of working O NOT use retired)	7	6b. Kind of Business/Industry
21215-0036 ad within 72 hours att gliene. er than "natural", or the Medical Exert	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	RIGERATION MECHANI	[C	RAILROAD
Maryland of 2 should be file in and Mental Hy to is marked othe traumetic event.	To Be	17. Father's Name (First, Middle, Last) DAVID H. HUGHES	18. Mother's Name (	BE GARL	AND
and 2 sho and 2 sho n 27 is m			G Address (Street and Number or Rural of OLD BACHMAN VALLEY		City or Town, State, Zip Code) ESTMINSTER, MD 21158
Baltimore, Misperial Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra			atory or other place)		Oc. Location - City or Town, State
Baltim Permit. Par Departmen Important:		21. Signature of Funeral Service Licensee 1 1 22.	ANCH CEMETERY 9/8/ Name and Address of Facility		ESTMINSTER, MARYLAND 91 WILLIS ST.
Bal permi Depa Impo any is					,P.A.WESTMINSTER, MD
Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each lin- Immediate Cause (Final disease or condition resulting in death)	ATOPY FALL	_URE	st, Approximate Interval Between Onset and Death
Examiner executed an and trial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	PHYSEMA		20415
Bo. Bo	Physician/Medical		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
S, S,	ρ	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
Vital Record vician: The law requirements on the law requirements on the law rector, page 2 should	Completed	Υ		24a. Was an autopsy perform	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
of Vita Of Vita Physician: this certific	o Be	25. Was case referred to medical examiner?  1  Yes 2	26. Place of Death ( 3 DOA  Other: 4 Nursing Home		)
After Fune	-	27. Manner of Teath  1/ Natural 5 Pending 2 Accident investigation  28a. Dete of Injury (Month, Day Year)  28b. Time of Injury			v injury occurred
Divisio  Divisio  To the Hospital or Attend! within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre-building, etc. (Specify)	et, factory, office	8f. Location (Stre City or Town,	set and Number or Rural Route Number, State)
Hospi 24 hour 5 Funer ately fill	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	occurred at the time, date and place, an estigation, in my opinion, death occurred	nd due to the cau d at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)
To the within To the comple	Med	29b. Signature and fittle of certifier	29c. License number	296	d. Date signed (Month, Day, Year)
		30. Name and ress of person who completed cause of death (Item 23a) (Type, P	D 29 24 6	1-	9/5/04
10		N. RATORDA MD 224	washing on t	Con h	21157
Sta Registra		31. Date filed (Month, Day, Year) 32. Register's Signature SEP 0 9 2004	South		

,	State o	f Maryland /	Department
ite cietros			Certificate

	4	For State Registrar		State of Ma	ıryland		irtment of F tificate of		nental Hy	giene Reg. No		20601
			e (First, Middle, La	st)	-				2. Date of De	ath Da	y Year	3. Time of Death
Physicia /Medica		Claire	Eliza	beth Ha	nnan				August	23	2004	8:30 A <sup>M</sup>
Examine		4a. Fecility Name (	If not institution, give	street and number)			4b. City, Town, o	r Location of Death		4c	County of Dea	th
	X 12	Forest	Glen Nurs	sing Home			Silver S	1 0			ontgome	
Funeral		5. Social Security N		ex 7. Age	(In yrs. la:		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	ay, Year)	9. Bir	thplace (State or Foreign ountry)
Director	-	549-44-2	2140		73	Yrs.			June 2	2, 1	931   Nev	y York
and and		Usual Residence o	10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
Manyl 1 sho ied a	٥	Maryland	Montgo	nerv	Gar	ithers	shurg					1 ☐ Yes 2 X No
the 288	Director	10e. Street and Nu					10f. Zip Code			10g. Cit	izen of What C	ountry?
3a or		18427 H	allmark C	ourt			2087	9		Uni	ted Sta	ites
death ms 2	Funeral	11. Marital Status		12. Was Decedent E Armed Forces?	Ever in U.S.	. 13. \	Vas Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	p-	14. Race - Ame Black, Whi	
or ite	E.	1 Never Marr	ried 2 Married	1 ☐ Yes 2 📉 N	lo		Yes 2X No		o riican, etc.)		Specify:	
filed within 72 hours after death with the Maryland Hygiene. yther than "naturel", or items 23a or 28a-f show ant, the Medical Evantinet must be redified at	d by	3 X Widowed		Year or Dates:							MI	nite
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withir sne. then	d L	Elementary/Seco	ondary (0-12)	College (1-4or 5	+)		board Op			Nur	sing Ho	ome
Hygie ther ont, III		17. Father's Name	(First, Middle, Last,	· · · · · · · · · · · · · · · · · · ·		WICCII	bourt op	18. Mother's Nam	ne (First, Middle	J		
d be ental	To Be	Stephen	Joseph O	'Reilly				Margare	t Ann K	irby	,	
Shoul od Me mark mark	ř		lame/Relationship (			19b. Mailir	g Address (Street	and Number or Rui				Zip Code)
nd 2 lith a 27 is r trau		Andrew	J. Hanna	n / Son		18427	Hallmar	k Court	Gaither	sbur	g, MD 2	20879
s 1 au f Hea item othe		20a. Method of Dis	,		20b. Pla	ce of Dispo	sition (Name of natory or other pla	ce)	Date	20c. L	ocation - City or	Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan pepermit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Experiment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.			Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State			tan Crem	Hug	3. 23, 304	Alex	andria.	Virginia
mit. partir sorta / inju		21. Signature of F	unaral Service Licel	Tage /	)====	22	. Name and Addre	ss of Facility De	Vol Fur			
Depar Impor any ir		A Flesh	A.A.	Mol		10	E. Deer	Park Dr.	Gaith	erst	ourg, M	20877
THE CO.		23. Part1. Enter shock, or ha	e dise se, or com	plications hat caused one cause on each lir	the death.	Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
Physician		Immediate Cause disease or conditi	(Final				Infarcti					Onset and Death Sudden
/Medical		resulting in death)	(	Due to (or as								
Examiner	_	Sequentially list of	onditions,	b								
pe sit	Examiner	Sequentially list co if any, leading to it cause. Enter Und Cause (Disease of	mmediate erlying	Due to (or as	a conseque	nce of):						
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ficate be executed in physician and its the burial-transition.	edlcal		•	d								
	an/Me	IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, outcome							23d. Date of de	livery
The law requires that the death cert are the has been signed by the attending page 2 should be detached for use a	O	in the past 12	2 months?	1□Live birth 4□Pregnant at			Ectopic pregnanc Other (specify) _	y			Month	Day Year
that the de led by the a detached t	Physi	9 Unknow		9□ Unknown								
res that igned b	by P	_		contributing to death b		_	,	en in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
v require been sig should b		Arte	riosclero	tic Cardio	vascı	ılar D	isease		1 🗆	Yes 2	□No 3□P	robably 4 🖔 Unknown
law re as bec 2 sho	Completed								24a. Was		24b. Were a	utopsy findings available completion of cause of
The tage page	Ho								perf	ormed?	death?	2 No
	Bec	25. Was case refe	erred to medical					26. Place of Dea				
nysic nis ce direc	20	examiner? 1 □ Yes 2🎇	Q No	Hospital: 1 Inpatie	nt 2□E	R/Outpatier	t 3 DOA Ott	ner: 4   Nursing H	ome 5 Res	idence	6 □Other (Spe	icity)
Attending Physician: If death, ector: After this certification by the funeral director,		27. Manner of Dea 1 X Natural	ath 5 Pending	28a. Date of Inju (Month, Da)	Year) 2	28b. Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe	how inju	ry occurred	-
tendi eath. or: A	catl	2 Accident 3 Suicide	investigatio 6 □ Could not b					Yes 2□No				
or Att	Certification:	4 Homicide	dataminad		ury - At hom c. (Specify)	ne, farm, str	eet, factory, office		City or To			ural Route Number,
To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier	17 Cartifuing Pl	nysician: To the best	of my know	ledge death	occurred at the fi	mo data and place	and due to the	201150/0	and manner a	r stated
Hos 24 ho Fun stely t	edical	(Check only one)		miner: On the basis of and manner sta	examination							
To the within 2 To the complet	Me	29b. Signature and	d title of certifier	1/			29c. Licens	se number		29d. Da	te signed (Mon.	th, Day, Year)
F ≯ F ŏ		Mu	an L	Tub			D066	7/1		Δ1101	ıst 23,	2004
2		30. Name and add	dress of person who	completed cause of d	eath (Item :	23a) (Type.		7 4		Augi	.J. 2J,	2007
<i>U</i>			Lenkin, N					heaton, N	Maryland	1 209	902	
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Registra	ar		AUG 24 2	2004 120	erra	F	Spark					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for Stata Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 21, 2004 Ruth Eugenia Harding 10:28 aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Health Care Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Nov. 8, 1913 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 1 F 90 Nov. Director 578-42-1133 Washington, DC Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
I a marked other than "natural", or Itams 23a or 28a-f show 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits itam 27 la marked othar than "natural", or Itams 23a or 28a-f show othar traumatic avent, the Medical Examenar must be invitibled at Maryland Montgomery Silver Spring 1 ☐ Yes 21 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2305 Shorefield Road 20902 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pernit. Pages 1 and 2 should be f Department of Health and Mental I Important: If itam 27 Ia marked of ဂ္ Joseph Augustus Stranley Jeanette Pettet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marvin Harding/ Husband 2305 Shorefield Road, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn 20a. Method of Disposition Date 20c. Location - City or Town, State August 26 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ŏ \* 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 2004 Memorial Park 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. any it 500 University Blvd., W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comshock, or heart failure. List only tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. mmediate Cause (Final Physician Acute Pneumonia 1 Week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events burial-trar resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) the þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Cardiovascular Disease Arteriosclerotic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate 1 Yes 2X No or Attanding Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 🗌 Yes 20 No Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 2004 wew no CX.R 30. Name and a ress of person who come eted cause of death (Item 23a) (Type, Print) 2309 Shorefield Rd, Silver Spring, Md 20902 Myron Lenkin, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 24 2004 oaks!

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

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	Examiner	4a Facility Name (If not inst	Co.			0			b. City, Town, o	-		c. County		4
		BROOKE GROVE	-				-	r 1 Year	SANDY If Under 24 Hr	SPRIN		4011	GOME	
	Funeral Director	5. Social Security Number 129–12–1076		7. A	ge (In yrs. Ia 86	st birthday) Yrs.	Months		Hours Mir		Day, Yea	§17	New	e (State or Foreign York
deeth with the Maryland	<b>№ ≡</b>	Usual Residence of Deceder 10a. State 10b. Co			10c. City,	Town or Loc	ation						10d.	Inside City Limits
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_ jē	or items 23e or 28a-fs rainer must be notified Funeral Director	11. Marital Status 1 □ Never Married 25	12	. Was Decedent Armed Forces 1 Tyyes 2 ☐ If Yes, Give	t Ever in U,S				spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or into Rican, etc.)	No-	Blac	e - American ck, White, etc /: White	
-0020 Phours efter	- A	3 ☐ Widowed 4 ☐ Div	edent's Educa	Year or Dates:	1943-	16a Decedi	ent's Usu	al Occupa	ation		16b.		usiness/Indus	
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D 2	d other the event, the Be Com	17. Father's Name (First, Mi	ddle, Last)			110111	eman		18. Mother's Na	ame (First, Mid	dle, Maide			
la be		John Charles	Hoenn	inger					Veror	nica Do	novar	ı		
Mary d 2 shou	hand is me traum	19a. Informant's Name/Rela			đ		-		and Number or H e Frede:					ode) g, MD 2090
Baltimore,	or other	20a. Method of Disposition 1   Burial 2 □ Crema 4 □ Donation 5 □ Oth		noval from State	20b. Pla	ace of Dispos metery, crem 'Lingto	sition (Na natory or On Na emete	other place ition	ål	Sept.	7		City or Town	, State rginia
Baltin permit. P	Departmen Important: any Injury once.	21. Signature of Funeral Se	76	20	22. F'r	Namea	nd Addres	ss of Facility Collin Sity Bly	s Funer	al H	ome ]	Inc.	Md 20901	
		23a. Part1. Enter the disea shock, or heart failure	se, or complica	itions that cause	ed the death.	Do not ente	or the mo	de of dyin	g, such as cardi	ac or respirator	y arrest,		Ar	pproximate terval Between
E	xaminer	Immediate Cause (Final disease or condition resulting in death)	a	SMALL		as a consequ			MAO	FTHE	LU	NG	10	MONTHS
68760, ifficete be exacuted	g physician and es the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C			as a consequas a consequ								
Box	attendin for use clan/N		d											
deat	ed for	Part II. Other aignificant co	nditions contri	buting to death i	but not resul	lting in the un	derlying	cause giv	en in Part I.	23b. C	id tobac	co usa co	ntributa to th	a causa of deeth?
ords, P.O. Box requires that the death cert	ned by the a detached f	CHROPIC O	BSTRU	CHUE	PULI	NON	ARY	Dis	SEASE	- 1	☐ Yes	2□ No	3 Probat	oly 4⊡Unknown
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I Rec	page 2									1	☐ Yes	2 XNo	1 □ Y	′es 2□No
	certificate rector, pag	25. Was case referred to m	edical						26. Place of D	eath (Check on	lv one)		1	
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g Phy	h. After this funeral d tion: To		ending			28b. Time of		28c. Injun Wor		28d. Descri				
Division or Attending	efter death.  Director: Affin by the fur  ertification	27. Manner of Death  1. Natural 5 Pending investigation  3 Suicide 6 Could not be determined  4 Homicide 28. Date of Injury (Month, Day Year)  28b. Time of Injury Ndr?  1 Jest Suicide 28b. Time of Injury 28b. Time of Injury 38b. Time of Injury 48b. Time of Injury 4b. Time o					Yes 2□No		n (Street Town, Sta		er or Rural R	loute Number,		
Di Hospital or	within 24 hours efter death.  To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier 1€ Ce (Check only 2 Ma	rtifying Phyalo	ian: To the best	t of my know	rledge, death	occurrec	at the tim	ne, date and place	ce, and due to to	he cause ne, date a	(s) and ma	anner as state and due to th	ed. e cause(s)
T et	the F nplete	one)	one) and manner stated.											
5	Z con	29b. Signature and title of o	ertifier									_		
	10	Mill	- STA		SICIA	, <u></u>		140	4046		the	GUS	T 19	2004
		30. Name and address of produce BLOOK		FMAN,	death (Item	23a) (Type, F	Print) SUA	085	2046 cHool	ROAD S	ANDY	SPR	ING N	12860
39	State	31. Date filed (Month, Day,			trar's Signati	ure &	de	aks	1		1			

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** Hartley August 21, 6:05a Esta 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 13 Scarlet Sage Court Burtonsville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🙀 F Yrs. 49 Kentucky Director 407 84 5842 June 11, 1955 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be nutified at 1 ☐ Yes 2 No Funeral Director Maryland Montgomery Burtonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Scarlet Sage Court 20866 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (C)No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status .07 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Analyst Finances 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or either traumatic event once. Be Paul Hicks ဥ Dolores Henzerling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Hartley/Husband 13 Scarlet Sage Court, Burtonsville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Francis J. Collins Funeral Home, Inc.

500 University Boulevard, West, Silver Spring, Maryland 20901

Approximate

Approximate

Approximate 22. Name and Address of Facility 21. Signature of Funeral Service Licens Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Liver Cancer -Primary 18 Months resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No certificate 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5x Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) After the 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pendina death. 1 ☐ Yes 2 ☐ No investigation Director: 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McClain, MD, 321 Prince George Street, Laurel, Maryland 20707 Timothy P.

Registrar

State

31. Date filed (Month, Day, Year)

AUG 23

sacker

32. Registrar's Signature

2004

			for State Registrar	State of Ma		d / Depa	artme		ealth a		ental Hy		•	†	20000
	_		Decedent's Name (First, Middle, Last	it)					-		2. Date of De	-	. U.L.	100	3. Time of Death
	Physicia				HONG						Month	Da	•	rear .	N
	/Medic		4a. Facility Name (If not institution, give		HONG		4b. City	. Town, or	Location of	of Death	Augus	40	1,20 County of	0 4 Death	10:55a
	Examin	er	7513 Citadel I				1		e Pai						eorge's
	unaval		5. Social Security Number 6. Sec		e (In yrs. la	ast birthday)		er 1 Year	If Under	24 Hrs.	8. Date of Birt (Month, Da				
	uneral irector				65	Yrs.	Months	Days	Hours	Min.	Jan.	y, Year) 9 _ <b>1</b>	939	Coun	lace (State or Foreign htry) Korea
			Usual Residence of Decedent										-		ROLEA
ylan	how		10a. State 10b. County		10c. City,	, Town or Lo	cation							1	0d. Inside City Limits
Ma	e-f s	cto	Maryland Prince	George's	Col1	.ege P	ark								1 XYes 2 □ No
£	or 28	ire	10e. Street and Number				10f. Z	ip Code				10g. Ci	izen of Wh	at Cour	ntry?
within 72 hours after death with the Maryland	nd other than "natural", or items 23a or 28e-f show event, the Medical Examiner must be notified at	Funeral Director	7513 Citadel Driv	<i>r</i> e				207	40			S	. Kor	ea	
dea	ems er m	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	3. 13.	Was Dec	edent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	-		Americ White,	an Indian, etc
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ed within 72 hours af	han Ma	d m	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT	use retired	)						
<b>7</b> 5	her t		12 17. Father's Name (First, Middle, Last)			Carp	ente	<u> </u>	19 Motho	rla Nama	(First, Middle,	Co	nstru	ctic	on
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id 2 should be tite	na -3		19a. Informant's Name/Relationship (7) Chong Hong / Wife	ype, Pnnt)			-				Route Numbe				Code)
	important: If item 27 is marks any injury ocothar traumatic		20a. Method of Disposition		20b Pla	ace of Dispo			DI. C		ge Park	-	ocation - C		State music
Seg	= 3/2		1 😾 Burial 2 🗆 Cremation 3 🗆		CA.	metery cres	natory or	other place	e) λ					-	ville, Md
. Pa	it and		`4 Donation 5 Other (Specify		Lax				1		23, 200	4 .	Javiu	SON	riie, Ma
Daltillor,	ny in		21. Signature of Funeral Service Licen	8	1/	- D	2. Name a ona lo	and Addres	s of Facilit Borow	ardt.	Funera	1 H	ome.	PA	
- 20	1.2 e o		Norale U/	July July							Funera Belts		le, M	d. 2	20705
	п		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused one cause on each li	the death. ne.	. Do not ent	er the mo	de of dyin	g, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between Onset and Death
Phy	sician		Immediate Cause (Final disease or condition	. Metas	tatic	Lung	Cano	er						6	months
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The law requires that the death certifical	ding p	Physician/Med	IF FEMALE:	22 s If was sutname	of program										
aath ceri	or us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal	death 3		pregnancy				3	23d. Date Month		ny Day Year
9	the e	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of de	ath 5L	Other (	specify)				- 1			,
hat the	ed by the e		Part II. Other significant conditions o	ontributing to death b	ut not recu	Iting in the u	ndarhina	cause and	n in Part I		23a Did tr	phacco	rse contrib	ute to th	e cause of death?
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Physician: T	is certificate director, pag	Be	25. Was case referred to medical examiner?							of Death	(Check only o	ne)			
Physic	S D	၉	1 ☐ Yes 2 🙀 No	Hospital: 1 Inpatie	ent 2 🗆 E	R/Outpatier	t 3□ 0	Othe Othe	ar: 4 □ Nu	rsing Hon	ne 5 Resid	ience	6 Other	(Specify	/)
	ner		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury		28c. Injury Work	at	2	8d. Describe h	now inju	ry occurred	1	
Attanding	tor: Aft the fun	atic	2 Accident investigation				М	1 🗆 '	res 2□1	No					
or Attanding	Diractor: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj	ury - At hor	me, farm, str	eet, facto	ry, office		2	8f. Location (S City or Tox			or Rura	l Route Number,
To the Hospitel or within 24 hours after	To the Funeral Direct completely filled in by	Cer					_								
ospi	unar ly fill	cai	29a. Certifier   (Check only 2   Medicel Exert	ysicien: To the best niner: On the basis o	of my know	vledge, deatl	n occurre	d at the tim	e, date an	d place, a	nd due to the	cause(s	and manr	ner as st	ated.
He H	tha F	Medical	one)	and manner sta	ated.										
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,	4		30. Name and address of person who												
			Sajeev Anand, MD 7				у <b>,</b> G	reenb	elt,	Md.	20770	_			
	Sta		31. Date filed (Month, Day, Year)  AUG 26 20	32. Registr		ure 4	1	uls							
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For 1 State	St	ate of Mar	yland / Depa			Mental Hy	giene			
Registrar			Ce	rtificate of	Death	1	Reg. No:	Ant	1226	2.0
Physician	ne (First, Middle, Last)	1 17 1				2. Date of De Month	Day 21,	2004	3. Time of I	-
/Medical	Danie		Huynh	T		August			9:18	Рм
LXamme	(If not institution, give stree		_		r Location of Dea	th		ounty of Deeth		
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Funeral. 5. Social Security	1771 14	20 5	(In yrs. last birthday)	Months Days	Hours Min	. (Month, Da	y, Year)	Cot	nplace (State or untry)	Foreign
Director 586-50-5	982	/	74 Yrs.		<u> </u>	August 9	, 1930	Vie	tnam	
0	10b. County		IOc. City, Town or Lo	ocation					10d. Inside City	y Limits
Maryland	Montgomery		Rockvi	11e					1 ☐ Yes	2 🔀 No
Maryland 10e. Street and No				10f. Zip Code			10a. Citize	n of What Cou	untry?	
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There is a superior of the sup	12. V	Vas Decedent Ev	er in U.S. 13.			Specify Yes or No		Race - Amer		
1 Never Ma	A	rmed Forces?  ☐ Yes 2 No		Was Decedent of H If Yes, specify Cub	an, Mexican, Puè	rto Rican, etc.)		Black, White		
S S S S S S S S S S S S S S S S S S S		Yes, Give 'ear or Dates:		1 ☐ Yes 2 🔯 No	Specify:		S	pecify: As	ian	
d within 72 hours at given and supplementary, or then "natural", or the "natural", or the "natural	15. Decedent's Educatio	n , , ,	16a. Dece	dent's Usual Occup	ation			of Business/I		
N Elementary/Sec	ecify onfy highest grade cor	npietea) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wo d)	orking	_	-	County	
Complete (See See See See See See See See See S	(5 12)	2		arian			Publi	c Libr	ary	
Defined within 72 hours after death with the Maryland of the matter of the Maryland of the Mar	(First, Middle, Last)				18. Mother's Na	ime (First, Middle,	Maiden Su	ımame)		
Dund Dund Dund Dund Dund Dund Dund Dund	ynh				Ruong	T. Nguy	en			
19a. Informant's I	Name/Relationship (Type, F	Print)	19b. Maili	ng Address (Street	and Number or F	iural Route Numbe	er, City or T	own, State, Zi	ip Code)	
Kim-Chi	Huynh-Pham /	Daughter	19907	Sugar Notel	n Circle,	Montgomery	Villa	ge, Mary	land 2088	86
20a. Method of Di	•	val fram Ctata	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	се) А	Date 26	20c. Loca	tion - City or T	Town, State	
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n adesa	Kelle Burns	f M	$01305 \begin{vmatrix} \mathbf{R} \mathbf{C} \\ 3 \mathbf{C} \end{vmatrix}$	0 West Mon	npniey ru tgomery Av	enue, Rock	ville,	Marylar	nd 20850-	2805
23a. Part1. Enter	the disease, or complication art failure. List only one car	ns that caused th	ne death. Do not en						Approximate Interval Betw	
Immediate Cause	(Final		ry Artery	Disease					Onset and De Years	eath
/Medical disease or condit			consequence of):	Discase					rears	
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if any, leading to cause. Enter Unc Cause was to that initiated even resulting in death.	or injury									
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The law requires that the death certificate be executed that the death certificate be executed that the death certificate be executed that the death certificate be executed that the death certificate be executed that the death certificate be executed that initiated executed that it is caused by the attending physician and cause. Extent one cause (Disease)  It is considered by the attending physician and cause in the burial transit of that is considered by the cause of the considered by the con	d									
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in the past 1	. □ No	□Pregnant at tii	me of death 5	Other (specify)				Month	Day Ye	ear
hat the death centified by the attending	'n									
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The law requirements of the la						perfo	rmed? 2 🔯 No	death? 1 ☐ Yes		
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LIVISION OF VIEW Control of the Cont	□ No Hospi	tal: 1 ☐ Inpatient	2 X ER/Outpatie		4   Nursing	Home 5 Resid	dence 6	Other (Speci	ify)	
27. Manner of Der	ath 28	Ba. Date of Injury (Month, Day 1	Year) 28b. Time o	Wor		28d. Describe f	now injury o	ccurred		
DIVISION  Teal or Attending Property of in by the funers of in by	investigation 6 Could not be			M 1 🗆	Yes 2 □ No					
Suicide  3 ☐ Suicide  4 ☐ Homicide	dotorminod	Be. Place of Injury building, etc.	y - At home, farm, st <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tov		lumber or Rui	ral Route Numbe	e <i>r</i> ,
Hosel Hours (Check only	1  ☐ Certifying Physicia  ☐ Medicel Exeminer:	On the basis of e	xamination and/or in	h occurred at the tir exestigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time.	cause(s) an	d manner as a	stated. to the cause(s)	
this can be designed by the control of the control		and manner state	od.							
29b. Signature an	To this of certifier	/		29c. Licens				igned (Month,		
10	minse	F	11)	D517	24		Augus	t 23,	2004	
30. Name and add	dress of person who comple				Vanadaat	on M	1004	20805		
24 Day 61 1 44		32. Registrar	necticut	Avenue,	kensingt	on, mary	rand .	20093		
	AUG 25 2004	/	s signature	Spork	,					

		1	For State Registrar	State of Marylar		irtment of H			giene	004	28690
		,	Decedent's Name (First, Middle, L					2. Date of Dea	ath Day	Vand	3. Time of Death
	Physicia /Medic		NOEL	E	4457	EN		08	19	2004	11:00 AM
	Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or	Location of Death	0111		County of Deat	
			WASH INGTON,	ADVENINST H	USPITA	2 TAK	COMA	PARK	,		MERY
Nik s	Funeral Director		5. Social Security Number 6. 565-52-4251	Sex 7. Age (In yrs. 1⊠ M 2□ F 63	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Month Day May 31,	h 194	9. Birtl Co Kan	hplece (State or Foreign untry) .S.a.s
	p ,		Usuel Residence of Decedent  10a. State 10b. County	10c Ci	ty, Town or Loc	cation					10d. Inside City Limits
	aryla shov	2	VA Prince		iangle	cation					1 □ Yes 2X No
	the M	Director	10e, Street and Number	WIIIIalli II.	Langie	10f. Zip Code			10a, Citiz	en of What Co	untry?
	with		18310 Nob Hill	Drive		22172			U.S.		
	ns 22	era	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. V	Vas Decedent of H	ispanic Origin? (S	pecify Yes or No		4. Race - Ame	
36	filed within 72 hours after death with the Maryland Hygion. Ither than "naturel; or Items 23a or 28a-f show ent, Ite Madical Examiner invalies inclified at	by Funeral	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ⊠Yes 2 □ No10/  If Yes, Give Year or Dates: -9/3	3//4	f Yes, specify Cuba I□Yes 2⊠ No	in, Mexican, Puert Specify:	o Rican, etc.)		Black, White Specify: B	e, etc. ·lack
21215-0036	2 hou		15. Decedent's	Education	16a. Deced	lent's Usual Occupa		ting	16b. Kin	d of Business/	Industry
212	hin 7.	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired	during most of wor	Kilig			
7	giene giene er the	Sorr		2	Logis	tician				.M.C.	
Maryland	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, train	Be (	17. Father's Name (First, Middle, La				18. Mother's Nan			Sumame)	
<u>ya</u>	should be and Mental a marked o umatic eve	2	William Noel Hy					Ola Ber		- 0	
Jai	12 sh and 18 m		19a. Informant's Name/Relationship			g Address (Street a				10wn, State, 2	up Code)
	1 and 2 Health tem 27		Stella L. Hyste 20a. Method of Disposition	n ,Wile		Box 497, sition (Name of natory or other place		Date VA	2172 20c. Loc	ation - City or	Town, State
סר	Mages nent of I		1 Burial 2 ☐ Cremation 3	Memoval Itom State		natory or other plac Nat. Cem		27,2004	Trio	nala I	17 A
Baltimore,	- 5 E E -		*4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice			. Name and Addres		mes Fun			
Ba	Departi Departi Impo		Demand C	· Amos	89	14 Quarry					
10			23a. Part1. Enter the disease, or co shock, or heart failure. List or	implications that caused the dea							Approximate Interval Between
	Priysician		Immediate Cause (Final	SEPS	15						Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a conse	quence of):						
	Examiner		Conventingly liet conditions	ASCV	D						
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):						
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
760,	ate be executed hysician and he buriat-transit		leading in death) Last	Due to (or as a conse	quence oi);						
00	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	dicai		d							
ox e	eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr					2	3d. Date of del	ivery
$\mathbf{m}$	death a atter	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)				Month	Day Year
o.	that the de led by the a detached f	hys	9 Unknown	9□ Unknown							
ď.	igned I be det	by P	Part II. Other significant condition	s contributing to death but not re	sulting in the ur	nderlying cause giv	en in Part I.				the cause of death?
ğ	w require been sig should t	ed						10,	Yes 2	]No 3∏Pr	obably 4 Qunknown
Records,	has be	Completed						24a. Was autop	osy	prior to	topsy findings available completion of cause of
œ.	The ate h page	Sor						perfo	252 No	death? 1 ☐ Yes	2 🗆 No
Vital	cian: ertific	Be	25. Was case referred to medical examiner?	Manadali		104		ath (Check only o	one)		
5	hysi this c	၉	1 XYes 2 No		28b, Time of		4   Norsing t	lome 5 Resid			cify)
n C	ling F	ion:	27. Manner of Death  1. Natural 5 Pending  2 accident investiga	28a. Date of Injury (Month, Day Yeer)	Injury	Wor	yat k? Yes 2 □ No	28d. Describe I	now injury	occurred	
isi	Attending in death. ector: Atterby the fune	Icat	3 ☐ Suicide 6 ☐ Could no	t be 200 Place of Injury - At I	home, farm, str			28f. Location (	Street and	l Number or Ru	ural Route Number,
Division of	lor A after Direction by	Certification:	4 Homicide determin	building, etc. (Spec				City or Tox	wn, State)		
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C		Physician: To the best of my kr raminer: On the basis of examinand manner stated.							
	o the	Me	29b. Signature and title of certifier	7		29c. Licens	e number		29d. Date	signed (Mont	h, Day, Year)
	- s - 0		(n/16)	MIN MO		MO	6031	9	0	8/19	104
	,2.		30. Name and address of person w	no completed cause of death (Ite	em 23a) (Type,		- 0 01		,	-/-	,
	12		Darcio 1	n Hamm	rer						
		ate	31. Date tiled (Month, Day, Year)	32. Registrar's Sign							
	Regist	rar	AUG 24	2004 Seneva	19	Spark	5/				

		4	State of Maryland / Department of H  State Certificate of L			ene NG A A I.	00001
			Registrar  1. Decedent's Name (First, Middle, Last)	704117	2. Date of Death	- U U +	3. Time of Death
	Physicia				Month	77 2004	4 1020 PM
	/Medic	al	Nann Jacqueline Hawks	Location of Death	Hugust	4c. County of Deat	
	Examin	er	and the state of t	20161-	_	1.1.1.	1
			Washington County Hospital  5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year.	If Under 24 Hrs.	8. Date of Birth	O Rid	tholace (State or Foreign
	Funeral		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	Hours Min.	May 5,19	(ear) Co	ryland
П.	Director	-	Usual Residence of Decedent	]	11ay 3,13	32 110	iry rana
	and and	ŀ	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Many	ō	Maryland Washington Hagerstown				1 X Yes 2 No
	the 288	Director	10e. Street and Number 10f. Zip Code		100	. Citizen of What Co	ountry?
	With Sa or		338 South Locust Street 21740			USA	
	ns 2:	era	11. Was Decedent Ever in U.S. 13. Was Decedent of Hi	ispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame Black, Whit	
36	d 2 should be filed within 72 hours after death with the Maryland in and Mental Hyglene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exam secretarity to notified a	by Funeral	1 Marital Status  Armed Forces?  If Yes, specify Cuba  1 Never Married 2 Married  1	Specify:	rican, etc.)		hite
Ö	hour tural		15 Decedent's Education 16a, Decedent's Usual Occup	ation		Sb. Kind of Business	/industry
<u>.</u>	n 72	Completed	(Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired	during most of worki d)	ing		
12	within ene. than	E	Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker			Domestic	
9	e filed withi al Hygiene. I other ther vent, the M		17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
Maryland 21215-0036	Mental Merked o	To Be	Leslie C. Hawks, Sr.	Ethel :	Irene Haw	baker	
7	2 should be and Mental is marked aumatic ev	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street	and Number or Rura	al Route Number, (	City or Town, State,	Zip Code)
$\mathbf{\Sigma}$	nd 2 s		Charles Churchey/Companion 338 South Locu	ust Stree	t, Hagers	stown, Md.	21740
	Heart the		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)			c. Location - City or	
Baltimore,			1 X Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Rest Haven Cemete	I	′2004 н.	acerstown	, Maryland
Ħ.	artme ortan injur		21. Signature of Funeral Service Licensee 22. Name and Address			-1	
Ba	permit. Page Department of Important: If any injury or once.						, Md. 21742
	100=1		23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	$E_i = 0$		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	allest	nate.	-	Onset and Death
	Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):	0 00071			ramos
	Examiner		Aut. Puly son	Syle	ua		while
	3	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	2 -			
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	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last    C.    Due to (or as a consequence of).	14			1.00 1
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89	tificate ng phy as the	edic					
XO	eath certific attending p for use as	Physician/Me	IF FEMALE:  23b. Was decedent pregnant  4 The bigh 3 December 3 December 3 represents			23d. Date of de	· ·
ă	leath atte	clai	in the past 12 mg/hths?  4 Pregnant at time of death  5 Other (specify)	y 		Month	Day Year
O.	that the de ed by the detached	Jys	9 Unknown				
σ.	ires that signed b	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	ven in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
rds	quire; n sign		Cha Observely & Philastray	Disease	e 1 Yes	2 □ No 3 0	robably 4 Unknown
Records,	w requir been si should	Completed	Occure our state of		24a. Was an	24b. Were a	utopsy findings available completion of cause of
Re	0 = 0	E E			autopsy perform	ed? death?	s 2 No
a	iicien: Th certificate rector, pag	C	25. Was case referred to medical	26. Place of Deat	th (Check onl one		
of Vital	Physicien: this certific ral director,	0	avaminar?	ner		nce 6 Other (Spe	ecify)
of	Phys or this oral di	<u> </u>	27. Manner of Death 28a. Da e of Injury 28b. Time of 28c. Injury Wo	ry at	28d. Describe how	v injury occurred	
on	ding F th: : After s funer	igo		Yes 2 □ No			
Division	or Attending ster death. Director: Afte	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my of	ime, date and place, opinion, death occur	, and due to the car rred at the time, da	use(s) and manner a te and place, and du	is stated.
	the H in 24 the F	ledical	one) and manner stated.			d. Date signed (Mor	
	To To	Σ	29b. Signature and title of certifier	COC ALL	25	A A	2 7 000
			Thought. Villa My DI	70 24	6	mg. do	July 1
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	OF H	aces 1 to	un mil	2/700
0	St	ate	31. Date filed (Mont A Dec Your) 2004 32. Segistrar's Signature	W 71.10	Justin	· ·	1770
1	Regist	rar	Jane 1. popular				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST CHARLES ALLEN JAMISON 2004 9:28 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner JOSEPH RICHEY HOSPICE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Oct. 11, 1958 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F Months 217-74-5124 45 Yrs. Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits item 27 is marked other then "neturel", or items 23a or 28e-f shov other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4803 Crowson Ave. 21212 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status illed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify:Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Custodian University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H em 27 Is marked ott George Arthur Jamison Celeste Amelia Bishop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lages 1 and 2 Leportment of Health an Importent: If item 27 Is m any injury or other Carol Taylor / niece 18 Graceford Drive, Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State R.A. Ferris & Co., Inc 8/30/04 <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) West Chester, PA 22. Name and Address of Facility
Lisa Scott Funeral Home, P.A.
552 Lewis Street, Havre de Grace, 21. Signature of Funeral Service Licensee dis Scott MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acquired immunodeticioney syndrome **Physician** unknown disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 No 2000 or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To uneral 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 0 80 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richey Hospice 150 32. Registrar's Sign 31. Date filed (Month, Day, Year) State AUG 3 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Month Roy Jacket 2004 /Medical 10 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alisbury Wiconuco Keninswa , Kegional redicas Center If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. **Funeral** 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 XM 2 ☐ F Director 124-22-9277 Usual Residence of Decedent Apr 12 1930 Buffalo, NY 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Sussex Frankford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Hidden Acres 19945 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other treumatic event, the Medical Exertiment Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other then \*r Elementary/Secondary (0-12) College (1-4or 5+) 12 Tool & Dye/Factory Worker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Roy Jacket Frances Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Nancy Jacket 13 Hidden Acres Frankford, DE 19945 If item 20b. Place of Disposition (Name of ny or other place)
Of 20a. Method of Disposition University ( Delaware 1 ☐ Burial 2 ☐ Cremation 3 🕱 Removal from State
4 🗖 Donation 5 ☐ Other (Specify) ò Department of Importent; If any Injury or once. 22. Name and Address of Facility Chandler Funeral Hoffie neral Service 21. Signature 2506 Concord Pike Wilmington, DE 19803 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) P.O. 9☐ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 🗆 No 1 🗌 Yes 2 🗖 No or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation M 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

84IVA

within 2

BENITO filed (Month, Day, Year) AUG 2 6 2004

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

han

State

Registrar

MA

29c. License number

2005

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

Theresa Pauline Kane    Mond   Medical Examiner	of Death 3. Time of Death of D				
Saminer   4a. Facility Name (if not institution, give street and number)   5hady Grove Adventist Hospital   Rockville   Rockville   Shady Grove Adventist Hospital   Rockville   Rockville   Shady Grove Adventist Hospital   Rockville   Rockville   Shady Grove Adventist Hospital   Rockville   Rockville   Rockville   Shady Grove Adventist Hospital   Rockville   Rockville   Rockville   Shady Grove Adventist Hospital   Rockville   Rockvil					
Funeral Director    Social Security Number   S	gust 22, 2004 9:30 at				
STATUTE   The part of the pa	Montgomery				
10a. State   10b. County   10c. City, Town or Location	o of Birth nth, Day, Year) 25, 1916 9. Birthplace (State or Foreign Country) Washington, I				
Elementary/Secondary (0·12)  College (1-4or 5+)  Homemaker  18. Mother's Name (First, Middle, Last)  Antonio Lazzari  19a. Informant's Name/Relationship (Type, Print)  Michael J. Kane/ Son  20a. Method of Disposition  1 Burial 2 X Cremation 3 Bemoval from State  1 Burial 2 X Cremation 5 Other (Specify)  21. Signat 6 of Funeral Service Licensae  1 Crematory  22. Name and Address of Facility Francis J. Collins Funer Soo University Blvd. W  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirated by the place of Disposition (Print of Specific Crematory)  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirated by the place of Disposition (Print of Specific Crematory)  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirated by the place of Disposition (Print of Specific Crematory)  25b. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	10d. Inside City Limit				
Elementary/Secondary (0·12)  College (1-4or 5+)  Homemaker  18. Mother's Name (First, Middle, Last)  Antonio Lazzari  19a. Informant's Name/Relationship (Type, Print)  Michael J. Kane/ Son  20a. Method of Disposition  1 Burial 2 X Cremation 3 Bemoval from State  1 Burial 2 X Cremation 5 Other (Specify)  21. Signat 6 of Funeral Service Licensae  1 Crematory  22. Name and Address of Facility Francis J. Collins Funer Soo University Blvd. W  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirated by the place of Disposition (Print of Specific Crematory)  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirated by the place of Disposition (Print of Specific Crematory)  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirated by the place of Disposition (Print of Specific Crematory)  25b. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	1 ☐ Yes 2 ☐ <b>x</b> N				
Elementary/Secondary (0·12)  College (1-4or 5+)  Homemaker  18. Mother's Name (First, Middle, Last)  Antonio Lazzari  19a. Informant's Name/Relationship (Type, Print)  Michael J. Kane/ Son  20a. Method of Disposition  1 Burial 2 X Cremation 3 Bemoval from State  1 Burial 2 X Cremation 5 Other (Specify)  21. Signat 6 of Funeral Service Licensae  1 Crematory  22. Name and Address of Facility Francis J. Collins Funer Soo University Blvd. W  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirated by the place of Disposition (Print of Specific Crematory)  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirated by the place of Disposition (Print of Specific Crematory)  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirated by the place of Disposition (Print of Specific Crematory)  25b. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	10g. Citizen of What Country?				
Elementary/Secondary (0-12)  College (1-4or 5+)  Homemaker  18. Mother's Name (First, Middle, Last)  Antonio Lazzari  19a. Informant's Name/Relationship (Type, Print)  Michael J. Kane/ Son  20a. Method of Disposition  1 Burial 2 **Cremation 3 Removal from State  1 Burial 2 **Cremation 5 Other (Specify)  21. Signat 6 of Funeral Service Licensae  Provided Lazion 1  22. Name and Address of Facility Francis J. Collins Funer Soo University Blvd. W.  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only dne pause on each line.  Provided Lazion 1  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	USA s or No- 14. Race - American Indian,				
Elementary/Secondary (0-12)  College (1-4or 5+)  Homemaker  18. Mother's Name (First, Middle, Last)  Antonio Lazzari  19a. Informant's Name/Relationship (Type, Print)  Michael J. Kane/ Son  20a. Method of Disposition  1 Burial 2 **Cremation 3 Removal from State  1 Burial 2 **Cremation 5 Other (Specify)  21. Signat 6 of Funeral Service Licensae  Provided Lazion 1  22. Name and Address of Facility Francis J. Collins Funer Soo University Blvd. W.  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only dne pause on each line.  Provided Lazion 1  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Black, White, etc.  Specify: White				
1   Burial   2x  Cremation   3   Removal from State   Metropolitan   2004	16b. Kind of Business/Industry				
Sequentially list conditions, if any, leading to immediate   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Metropolitan   Crematory   2004   Crematory   2004     Crematory   2004   Crematory   2004     Crematory   2004   Crematory   2004     Crematory   2004   Crematory   2004     Crematory   2004   Crematory   2004     Crematory   2004   Crematory   2004     Crematory   2004   Crematory   2004     Crematory   2004   Crematory   2004   Crematory   2004     Crematory   2004   Crematory	Orana Harra				
1   Burial   2x  Cremation   3   Removal from State   Metropolitan   2004	Own Home  Middle, Maiden Sumame)				
Sequentially list conditions, if any, leading to immediate   Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):    Metropolitan   Crematory   2004   Crematory   2004     Crematory   2004   Crematory   2004     Crematory   2004   Crematory   2004     Crematory   2004   Crematory   2004     Crematory   2004   Crematory   2004     Crematory   2004   Crematory   2004     Crematory   2004   Crematory   2004     Crematory   2004   Crematory   2004   Crematory   2004     Crematory   2004   Crematory	rari				
1   Burial 2x  Cremation 3   Removal from State   Metropolitan   2004	Number, City or Town, State, Zip Code) n Grove, MD 20880				
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat shock, or heart failure. List only disease on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	23 20c. Location · City or Town, State Alexandria, Virginia				
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only disease on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	ral Home Inc, Silver Spring, MD 209				
edical as the buy	Interval Batween Onset and Death				
The composition of the composi	23d. Date of delivery Month Day Year				
23e.	Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown				
24a.  24a.  1   Yes of the condition of	Was an autopsy findings available prior to completion of cause of death?  Yes 2 □ No 1 □ Yes 2 □ No				
27. Manner of Death 27. Manner of Death 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?  4 Nursing Home 5	Residence 6 □Other (Specify) cribe how injury occurred				
	tion (Street and Number or Rural Route Number, or Town, State)				
29a. Certifier  29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to a curred at the time, date and place, and due to a curred at the time, date and place, and due to a curred at the time.	o the cause(s) and manner as stated. time, date and place, and due to the cause(s)				
29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)				
10 P. Name and address of parson who completed cause of death /Hom 220/Time Brish)	August 22, 2004				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Shahyar Michael Gharacholou 9901 Medical Center  State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature  AUG 24 2004	Drive Rockville, MD 20850				

			1 - For State Registrar	State of Marylar		artment rtificate			and M	-	giene Reg. No. 🤈 🎧	0.1	20005
			1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month		Year	3. Time of Death
	Physici /Medic		Richard Ka	ipica						Aug.	16, 2004	+	7:30 P M
	Examin		4a. Facility Name (If not institution, give s	•				r Location o	of Death		4c. County	of Death	
			Southern Maryland			Clin		T 16 ( Inday	Od Hee		Prin		eorge
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. 69	last birthday) Yrs.	If Under Months	Days	If Under :	Min.	8. Date of Birt Month, Day Feb. 2	n Y Year) 1935	9. Birthr	olace (State or Foreign ntry) v York
	Director		Usual Residence of Decedent	09						reb. Z	3,1933	Nev	VIOIR
	yland		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation						1	10d. Inside City Limits
	Mar-f st	to	Maryland   Prince Ge	orge Fi	t. Wash	ningto	n						1X Yes 2 No
	or 28	Director	10e. Street and Number		· · · · · · · · · · · · · · · · · · ·	10f. Zip	Code				10g. Citizen of	What Cou	ntry?
	23a		2506 Henson Valley	Way			207					SA	
	within 72 hours after death with the Maryland ene. than "neturel", or Itams 23e or 28a-f show the Medical Examinar must be notified at	Funeral		<ol><li>Was Decedent Ever in U Armed Forces?</li></ol>	.S. 13.	Was Decede If Yes, spec	lent of Hi ify Cuba	ispanic Orig In, Mexican	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	14. Rad Bla	ce - Americk, White,	can Indian, etc.
36	s afte	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give 194 Year or Dates: 105		1 ☐ Yes 2	oN 🖾s	Specify:			Specif	v: Wh:	ite
21215-0036	ture!	edt	15. Decedent's Educ		16a, Dece	dent's Usua	I Occupa	ation			16b. Kind of B		
215	n 7	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of wor DO NOT us	rk done d se retired	during most f)	t of workii	ng			,
212	d with	Completed	Clementary/Secondary (0-12)	2	Office	e Spac	ce Ma	anage	r		US Gove	rnme	nt
9	al Hy al Hy fother	Be (	17. Father's Name (First, Middle, Last)								Maiden Sumar	ne)	
ylai	Ment Ment arked	70	Frank Kapica					Fra	nces	J. Spu	hler		
Maryland	2 sho and 4s ma		19a. Informant's Name/Relationship (Type			-					er, City or Town,		-
0	l and fealth im 27 her ti		Barbara Kapica/Wife					-	way	rt. was	shington 20c. Location		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neture!; or Itams 23a or 28a-f show array injury or other treumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re		Place of Disponentery, crei				ug.	19,			
單	Tan tan tan tan tan tan tan tan tan tan t		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Fuperal Service License</li> </ul>		tropol:				200 DeV		Alex.,		ınıa
Ba	perm Depa Impo any ii		21. Signature of Puberal Service License	Mel	24	z. Name and	u Addres	2222	Wis	consin	ral Hom Ave. N . 20007	.W.	
			23a. Part1. Enter the disease, or complic	cations that caused the dear									Approximate
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	14.	1	-			, ,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consec	June of):	20/0	الد	16-3				- 4	MARION-V
8	Examiner			Ph	ublo	My6	145	0				1	in Ilmound
		Je.	Sequentially list conditions, I only leading to immunate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons w	uence of):	/-	/						
	nd nd transi	Examine	that initiated events c										
90,	death certificate be executed e attending physician and of for use as the burial-transit		resulting in death) Last	Due to (or as a consec	quence of):								
8760,	cate b	dical										-	
9 X	death certifica attending pt d for use as t	Physician/Me	IF FEMALE:	Bc. If yes, outcome of pregn	ancv						224 Da	to of doing	
Box	atten for u	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3[	Ectopic pre Other (spe	egnancy <i>ecify)</i>	,				te of delivi inth	Day Year
o.	that the de led by the a detached	ysie	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		_ 0 0 10 1 (0)00	,						
<u>a</u>	The law requires that the ste has been signed by th bage 2 should be detache	by Pi	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying ca	ause give	en in Part I.		23e. Did to	bacco use con	tribute to t	he cause of death?
Records,	quire; n sig uld bu	d be	abite Renal.	Falue						1 □ Y	′es 2□No	3 Prob	oably 4 Dunknown
00	s been s s been s s should	ojet	netabolic	audosi	7					24a. Was	an 24b.	Were auto	opsy findings available impletion of cause of
Re	The law te has	Completed								autop perfor	rmed?	prior to co death? 1 🔲 Yes	
Vital		BeC	25. Was case referred to medical					26. Place	of Death	(Check only o			
of V	S S	ToE	examiner?	ospital: 1 phopatient 2	ER/Outpatier	nt 3 DO	A Othe	er: 4 ☐ Nu	rsing Hor	ne 5 🗆 Resid	lence 6 Oth	er (Specil	fy)
	ding Pt n. After th funeral		27. Manner Death  1 Patural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28	8c. Injury Work	y at k?	2	8d. Describe h	low injury occur	red	
Sio	uttsndiu death. ctor: A y the fu	catl	2 Accident investigation 3 Suicide 6 Could not be			М		Yes 2 □ I					
Division	l or Attsno after death Director: in by the	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	eet, factory,	, office		2	28f. Location (S City or Tow	Street and Numb n, State)	oer or Run	al Route Number,
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a Certifier 1 Dentifying Phys	ician: To the best of my kno	wledge doct	h occurred	at the *i	ne date a	d place	and due to the	20100/21 77	20007	tatad
	24 ho Fun stely i	Medical	(Check only one) Medicel Examir	er: On the basis of examina and manner stated.	ation and/or in	vestigation,	in my o	pinion, deal	th occurre	ed at the time,	date and place,	anner as s and due t	o the cause(s)
	ro the vithin o the omple	Me	29b. Signature and title of certifier			29c.	. License	e number			29d. Date signe	d (Month,	Day, Year)
	r > ⊢ ō		HartAnda	gump		C	· oi	150	1	1	Jules	t, 1	7,04
	5		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,	Print)		Arast	x Ya	Zdani ni	D. 0	/ /	1 -1
			9804 Chersin	Ave 3-4		lucy	26	2125	MD	20070	2		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	1.	1	- 11	,					
	Regist	rar	M110 9 4 20	na house	7	101	BUKE	21					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2004 12:45 AM AUA KESSELMAN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, NOV 8, 9. Birthplace (State or Foreign Days Hours Min 1 □ M 2 🔀 F NEW YORK 085-05-3166 88 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ¥Yes 2 ☐ No

ROCKVILLE

10f. Zip Code

the Maryland r than "natural", or items 23s or 28s-f show the Medical Exercit at must be notified at death Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within . Department of Health and Mental Hygiene. Important: If item 27 Ia markad other than "I any injuy or other traumatic event, tra Mengone. 5

Funeral

Director

MD

10e. Street and Numbe

MONTGOMERY

Privoician /Medical **Examiner** 

Vital death. 8

Examiner attending physician Physician/Medical the as esn esn the ρ Completed Be 2 Certification: Diractor: cal

Box 68760 P.O. ro the Hu.
within 24 hours
on the Funeral Dr.
rately filler

Director 10g. Citizen of What Country? 6105 MONTROSE ROAD 20852 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 2 Specify 3 XWidowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 'UNKNOWN' **ABRAHAM** HERSHKOWITZ ANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTIN KESSELMAN, COMMACK, NY 39 GLENMERE LANE, 11725 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2 Cremation 3 Removal from State 1 X Burial 4 Donation 5 Other (Specify) RIVERSIDE CEMETERY 8/25/2004 LODI, NEW JERSEY 21. Signature of uner J Service Ligen DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. Jak 1170 ROCKVILLE PIKE, ROCKVILLE, MD đ 23a. Part1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e, or complications that cause in Each line. Immediate Cause (Final disease or condition resulting in death) Respiration Distress Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2.200 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Osteoarthoses 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Vascular Discase Penphual 20 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ursing Home 5 Residence 6 Other (Specify, 2 No 1 🗌 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Letrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Shelpa ann, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROCKVILLE, MD

SHILPA AMIN, M.D., 6121 MONTROSE ROAD,

31. Date filed (Month, Day, Year) AUG 24 2004

32. Registrar's Signature Zanewa

oaks

D0002713

8/23/04

20852

State

Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 3:55 P **Physician** August 23, 2004 Knezevich /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | June 7,1921 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🗓 F Poland 83 578-50-3165 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Washington D.C. None 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 20016 USA 4201 Butterworth Place, NW #431 death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after artment of Health and Mental Hygiene. ortann: If them 27 is marked other then "natural", or the injury or other traumatic svent, the Modral Examina injury or other traumatic svent, the Modral Examina. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify ۾ 3 ₩ Widowed 4 Drvorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Geico 12 Insurance Adjuster 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Michael Kienkiewicz Janina Amon ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3222 Santa Monica Blvd.#8 Santa Monica, CA 90404 Bogdan Knezevich/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aug. 2 2004 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Crem. permit. Page Department Important: If eny injury o Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, D.C. 20007 21. Signature di Funeral Service Licensee enry s 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any learny to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No ŏ 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 ☐ Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 X No page 2 1 Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Medical Certification: To Be Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 5868 -26-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive; Rockville, MD Jude R. Alexander, M.D. 32. Registrar's Signature 31. Date liled (Month, Day, Year) State AUG 27 Registrar

			1 - For State Registrar	State of Man		artment of H rtificate of L			ene	01	2000
	Physici		Decedent's Name (First, Middle, Lass     THOMAS	EUGE1	VTE:	KANE		2. Date of Death Month August	Day Y	rear 004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	A deal	4b. City, Town, or	Location of Death		4c. County of		TOTOM
	Funeral Director		1402 Rigdon F 5. Social Security Number 6. So 219-44-8012		in yrs. last birthday)	Jarre If Under 1 Year Months Days	ttsvill If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y			rd ce (State or Foreign v) vland
	land		Usual Residence of Decedent  10a. State 10b. County	10	Dc. City, Town or Lo	ocation					. Inside City Limits
	Mary a-f sh	ţŏ	MD. Harf	ord		Jar	rettsvi	lle			1 ☐ Yes 2 No
	vith the	Director	10e. Street and Number		·	10f. Zip Code			. Citizen of Wh	-	
	Jeath v	Funeral	1402 Rigdon  11. Marital Status	12 Was Doodont Eve	or in U.S. 13.	Was Decedent of Hi	21084		United 14. Race -		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If ear 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 X No	n, Mexican, Puerto Specify:	Rican, etc.)		White, etc	
5-0	"natur	Completed by	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occupa kind of work done of	lurina most of worki	ing 16	b. Kind of Busin		
72	filed withir Hygiene. other then	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	//re.	00 NOT use retired, Bankei			Ra	nkin	n at
	be filed tal Hyg d othe	Be	17. Father's Name (First, Middle, Last)			Dante		(First, Middle, Ma			5
Maryland	should be tind Mental Is marked o	ဥ	Eugene  19a. Informant's Name/Relationship (7)	Time Print!	Kan	e ng Address (Street a	Hel			F	lood
	and 2 sho ealth and n 27 Is m		. ,	Wife		Rigdon		Jarret			
altimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tri once.		20a. Method of Disposition  1 Burial 2 Cremation 3	:	20b. Place of Dispo			Pate 20	c. Location - Ci	ity or Town	Id. 2108 , State
Ě	t. Pag rtment rtant: I		* 4 ☐ Donation 5 ☐ Other (Specify	2. 07	St. John	n Cemete	ery 8/30	)/2004 I	lydes,	Mar	yland
Ba	Depa Impo any I		21. Signature of Euneral San de Lice	len Tur	المنتال	2. Name and Addres  B.G. Kur	ts & Sc	rrettsy n Funer	al Ho	Mar me.	yland P.A.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	plications that caused the	e death. Do not ent	er the mode of dying	, such as cardiac o	r respiratory arrest	,	Ar In	pproximate terval Between nset and Death
ī	/Medical		disease or condition resulting in death)	a. Maliq Due to (or as a c	Insequence of):	lesot	nelier	na		14	months
	Examiner		Sequentially list conditions, if any, leading to immediate	b							
	ited nsit	Examiner	Cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of:						
oʻ	ficate be executed physician and s the burial-transit	Exai	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
68760,	cate be ohysici the bu	edical		d							
9 X O	death certifi e attending p id for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Date o	of delivery	
O.	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 □ 4 □ Pregnant at ti <i>m</i> 9 □ Unknown		Ectopic pregnancy Other (specify)			Month		y Year
rds, P.	The law requires that the tte has been signed by th bage 2 should be detache	β	Part II. Other significant conditions co	ontributing to death but n	ot resulting in the ur	nderlying cause give	n in Part I.	23e. Did tobac 1 ☐ Yes	co use contribu		ause of death? y 4 Unknown
I Records,		Completed						24a. Was an autopsy performed	? prio	r to completh?	findings available etion of cause of
Vital	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		Othe	26. Place of Death				
jo (	g Physier this	n; To	27. Manner of Death	1 ☐ Inpatient  28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	t 3 DOA 28c. Injury Work	4   Nursing nor	ne 5 Spesidence 28d. Describe how i		(Specify)	
Slor	ttending I death. ctor: After y the funer	catlo	1 Pending 2 Accident investigation 3 Suicide 6 Could not be		injury		es 2 No				
Division of	Hospital or Attending Physician: 44 hours after death. Funerel Director: After this certifici tely filled in by the funeral director,	Certification;	4 Homicide determined	28e. Place of Injury building, etc. (5	At home, farm, stre Specify)	eet, factory, office	2	28f. Location (Stree City or Town, S		or Rural Ro	oute Number,
	To the Hospital or Attenwithin 24 hours after deatle. To the Funerel Director: completely filled in by the	Medical (	29a. Certifier 1 Creatifying Phy (Check only one) 2 Medical Exam	/sician: To the best of m iner: On the basis of exa and manner stated	a <i>m</i> ination and/or inv	occurred at the time restigation, in my opi	e, date and place, a inion, death occurre	and due to the caus and at the time, date	e(s) and manne and place, and	er as stated	d. cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	20 1	76	29c. License			Date signed (A		
	LM		Gulias	Drahm	erth	DOG	20177	0 Je	ptem	ber	- 22004
	20		30. Name and address of person who of	ompleted cause of death	(Item 23a) (Type, I	Print) Ocleans	Stropt	Balti	navo H.	acul	- 22004 und 21231
	Sta Registr		31. Date filed (Month, Day, Year) SEP 7	32. Registrar's			(		101 00 11	7:00	-1401

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Yee **Physician** august 1408 Emmy Levy 300 /Medical 4a. Fecility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner County Hospita Hagerstown Washington was hington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 X F 79 Yrs Director 126-24-1008 June 9, 1925 Puerto Rico Usuel Residence of Decedent with the Maryland 10a State 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show emp injury or other traumatic event. The Medical Examinat must be notified at once. 10h County 10d. Inside City Limits 1 ☐ Yes 2 CZNo Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11104 Mountain View Circle 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 No Specify: Completed by Specify: puerto rican 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker 12 her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Montes Isabel Manzano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Hoffman - daughter 11104 Mountain View Circle, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park 8/31/04 Williamsport, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licenses trul L. Vestal 415 E.Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ntracrania Hemorrhace 5 hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav 4☐Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Hypelipidemia page 2 should Be Completed has been Drabeles Mellity 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? The law r certificate 2 🗆 No 1 Tyes 2 No 1 TYes Hospital or Attending Physician: tor: After this certific the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 240 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \ Homicide within 24 hours a To the Funerel I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D005743 571 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 251 East Antietam St Brand Hafferstown. CHRISTINE MP 31. Date filed (Month A G G Y e g) 0 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene , 1 - For State Registral Certificate of Death Reg. No.) 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 Year August 31, **Physician** 8:15 PM M Annabel Mae Lundgren /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick 8. Date of Birth July 8, 1909 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birtholace (State or Foreign 5. Social Security Number **Funeral** Pennsylvania Director 218-50-4810 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene ansi: If item 27 is marked other than "natural", or Itama 23a or 28a-f show ansi: If item 27 is marked other than "natural", or histman and item of the traumatic event. The Macical Experient is unit to institling at ury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10b Counts 10a State 14 Yes 2 □ No Frederick Frederick Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21701 200 East 16th Street Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian Black, White, etc. 11 Marital Status 1X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Donnelly William John Dunn ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 629 Colorado Ave., Baltimore, Maryland 21210 Katherine Dunn, niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory Sept. 4, 2004 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licente Keeney and Basford PA Funeral Home

106 East Church St., Frederick, Maryland 21701

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final o month, Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. F ed by the a 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 2 Ho 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an within 24 hours after death.
To the Funeral Director certificate 1 Yes 24110 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 EP/Outpatient 3 DOA 2 28c. Injury at Work? funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 Yes 2 No investigation 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and til September 1, 2004 o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person was Frederick Mr A1 ouk tel 31. Date filed (Month, Day, Year) 32. Regis State Registrar

			State of Maryland / Department of Health and I	Mental Hyg	jiene	
_			- State Registrar Certificate of Death		leg. No.	9701
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		Edward Brooke Lee, Jr.		20, 2004	7:41 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County of Death	
			Suburban Hospital Bethesda  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	9 Date of Birth	Montgomery	- /Ct-t Fi
74.0	Funeral Director		169-16-4166 1XIM 2□F 86 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day		ce (State or Foreign laryland
			Usual Residence of Decedent	perober	23, 1517	aryrand
	irylan thow	_	10a. State 10b. County 10c. City, Town or Location		10d	I. Inside City Limits
	ith the Marylar or 28a-1 show e notified at	cto	MD Montgomery Chevy Chase			1€ Yes 2 No
	or 2	Director	10e. Street and Number 10f. Zip Code	l l	0g. Citizen of What Country	/?
	death with the Maryland ms 23a or 28a-f show Linust be notified at	rai	8806 Connecticut Ave. 20815		J.S.A.	
	ter de	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☑ Married  12. Was Decedent of Hispanic Origin? (Start Forces) (Start	pecify Yes or No- o Rican, etc.)	14. Race - American Black, White, etc	
36	Ir, or	by F	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: Whit	e
ŏ	2 hou		15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/Indus	stry
215	thin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of work life. DO NOT use retired)	king		•
21	ed wil	Son	5+ Broker/Developer		Real Estate	
pu	be file tal Hy d oth	Be		ne (First, Middle, i	Maiden Sumame)	
yla	Men Men tarke	၉		th Wilson	<del>-</del>	
Maryland 21215-0036	12 sh h and h srr rsur		19a. Informant's Name/Relationship (Type, Print)  Brenda Baker Puderbaugh Lee/Wife 8806 Connecticut Ave			
e,	1 and Health am 2 ther t				Chase, MD 20  20c. Location - City or Town	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deportment of Health and Mental Hygiene. Importanted of Health and Mental Hygiene. Importants: if item 27 is marked other than "netural", or items 23a or 28a-f show any injuryer other traumatic event, it a Madical Eventinal near the rediffication.		1 ₺ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)			i, State
턆	a firman				Wash., D.C.	
Ba	Dep.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Jos 5130 Wisconsin Ave.			
			23a, Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac			pproximate
			snock, or heart failure. List only one cause on each line.		In	terval Between nset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			
B	Examiner		CONCECTIVE USA	CT F	Air van	2 20
250		ner	Sequentially list conditions, Tarry, leading to immediate cause. Enter Underlying Cause (Disease or injury		arcorce .	7/4.
70	icate be executed physician and the burial-transit	Examiner	that initiated events C.			
8,50	oe execian a		Due to (or as a consequence of):			
5	ficate b g physic as the b	edicai	d			
CT 000	- CD cd	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			
Bo	requires that the death certifeen signed by the attending hould be detached for use a	Physician/M	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delivery Month Da	ıy Year
ex 0	he de	ysic	1 Yes 2 No 9 Unknown  4 Pregnant at time of death 5 Other (specify) 9 Unknown			•
× 9.	that the ded by detail		Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to the o	cause of death?
LVDOX ecords,	uires n sign lid be	d by		1 🗆 Ye	s 2 No 3 Probabl	y 4 Unknown
3 5	S 0 8	ompieted		24a. Was ar	n 24b. Were autopsy	findings available
20 m	The faw te has b	m d		autops	prior to completed?	etion of cause of
		ပိ	25. Was case referred to medical	1 Yes 2		No
~ <u>~</u>	Physician: The far this certificate has ral director, page 2	0	examiner?		nce 6 Other (Specify)	
	E E =	L L	27. Mann Peath 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe ho		
ivision	Attanding Ir death.	ertification;	2 Accident investigation M 1 Yes 2 No			
\ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	or Attandatter deatt Director: in by the	tific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town	reet and Number or Rural Re	oute Number,
00	spital or Attan ours after deat aral Director: filled in by the	Cer				
Ó	the Hospital or nin 24 hours afte tha Funaral Dir npletely filled in I	edical	29a. Certifier (Check only (Check only and Check only control of the best of my knowledge, death occurred at the time, date and place, (Check only and Check only control of the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation. (Check only control of the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation.)	and due to the ca	use(s) and manner as state	d.
	To the Hos within 24 h To tha Fun completely		and manner stated.			
	To wit	~	29b. Signature and title of certifier  29c. License number		3d. Date signed (Month, Day	
	5		Collie 056065		08-21-5	γ γ
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Carlos E. Picone, M.D. 5530 Wisconsin Ave. #930 Chev	vy Chase	, MD 20815	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registr	- /	AUC 2 2 2001 Janes & Sparks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Tuey-Ping Lim August 18, 2004 10:00P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery

9. Birthplace (State or Foreign
Country) If Under 24 Hrs. 8. Date of Birth (Month Day, Year)

Feb 21, 1921 Montgomery General Hospital Olney
If Under 1 Year **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 F Months Days 83 Yrs. Director 579 88 6018 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mantal Hygiene. Importent: If item 27 is marked other than "netural", or items 23a or 28e-f show may highly or other treumetic event, the Medical Event and items to incline at once. 1 ☐ Yes 2 No Directo Maryland Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18024 Rockyridge Lane Completed by Funeral 20832 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Asian 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hee Shueng Lau Tam Fai Guen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18024 Rockyridge Lane Olney, Maryland Justin H. Lim / Son 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State George Washington Cem 8/22/2004 Adelphi, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Sadvice 11800 New Hampshire Ave Silver Spring, MD 20904 2da. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final Physician 7 days disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of): Examiner Lung Cancer 30 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0. the 6 9 Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 ☐ Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 **X**No 1 Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: ပ 1 ☐ Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after death To the Funeral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 / Homicide Hospital or 29a. Certifier 1 🛎 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Devet Morison m) D47682 August 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2901 Olney-Sandy Spring Road Olney, Maryland 20832 Bennett Morrison 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

AUG 24 2004

Damon Marcus Lewis 04-05414

RJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1541	41		1 - For State Registrar	tate of Maryland		artment of H		-			
	Physic		Decedent's Name (First, Middle, Last)	arcus Lewis			J (41)	2. Date of Dea Month August		Year	3. Time of Death 3
	/Medi Exami		4a. Facility Name (If not institution, give stre Prince George's Hos	et and number)		4b. City, Town, or			4c. County		
	Funeral Director		5. Social Security Number 6. Sex 1 X M	7. Age (In yrs. Ia.		If Under 1 Year Months Days	If Under 24 Hi Hours Mi	8. Date of Birth (Month, Day Septemb	, Year)1976	9. Birthplac	e (State or Foreign
Maryland	show led at	tor	Usual Residence of Decedent  10a. State  10b. County  District of Columb	_	Town or Lo					10d.	Inside City Limits 1X Yes 2 □ No
with the	s or 28e. De natif	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country	?
<b>-UU36</b> hours after death with the Maryland	rel', or Items 23a or 28e-f show Examiner must be natified at	by Funerai	20 Kenilworth Ave  11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give	13. \		019 ispanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No- into Rican, etc.)		States  - American k, White, etc.  - Black	
1215-0036 within 72 hours af	"natu	Completed	15. Decedent's Educati (Specify only highest grade co	Year or Dates: on impleted) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of w		16b. Kind of Bu		
De filled	ntal Hygiene. od other then event, II e M	Be	17. Father's Name (First, Middle, Last)			Painter		ame (First, Middle,	Maiden Sumam	e)	provement
aryla should	and Men s marke umetic	2	Ricardo Donzel  19a. Informant's Name/Relationship ( <i>Type</i> ,		19b. Mailin	g Address (Street a		Omega			ide) acces
Te, M	Health a tem 27 Is other tre		Ricardo Donzel Lewis	s, Jr.	2002	Maryland sition (Name of natory or other place	avenue,	N. E.; A	ashingto pt. 104 20c. Location -		
Saltimor	Department of Health and Ments Importent: If item 27 Is marked any injury or other treumetic e once.		1 XBurial 2 □ Cremation 3 □ Rem.  '4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	SVALITOTII OTATO	lona1	Harmony N	demorial		Landove	er, Man	
Derm Derm	Impo any ir once.		* Korranch	lew	6	00 Kenned	ly Stree	any Mort:	ashingto	Inc. on,D.C.	. 20011
	ysician Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death)	ons that caused the death. ause on each ling.  Due to (or as a conseque	e (	er the mode of dying	g, such as cardia	oc or respiratory are	est,	Int	pproximate erval Between aset and Death
u.	aminer	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conseque							
cate be executed	physician and the burial-transit	dicai Examiner	that initiated events c c d d.	Due to (or as a conseque	nce of):						
The law requires that the death certific	been signed by the attending p should be detached for use as t	hysician/Med	in the past 12 months?	if yes, outcome of pregnanc 1□Live birth 2□Fetal d 4□Pregnant at time of dea 9□Unknown	eath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day	y Year
olds, r	een signed b ould be deta	by P	Part II. Other significant conditions contrib	iting to death but not resulti	ing in the un	derlying cause give	n in Part I.	23e. Did tol	pacco use contri		ause of death?
in: The law	ate has page 2	e Completed	25. Was case referred to medical					/	ned? de 2□ No 1	ere autopsy for to comple auti?	findings available etion of cause of No
Physicien:	.e :=	To Be	examiner? 1 XYes 2 No Hosp	1 Inpatient 2 K EF	R/Outpatient		r: 4 🗌 Nursing l	ath <i>(Check only on</i> Home 5 ☐ Reside		r (Specify)	
To the Hospitel or Attending F	After funer	Certification;	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	8/21/04 G	8b. Time of Injury	28c. Injury Work 1 □ Y	?	De Leas	and al	at	
pitel or A	within 24 nous arer usar To the Funerel Director: completely filled in by the		4X Homicide	8e. Place of Injury - At home building, etc. (Specify)	stres	24		MACH. I	D.C.		ensous-swe
the Hosp	the Fune	edicai	29a. Certifier 1☐ Certifying Physicia (Check only one)	n: To the best of my knowle On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time estigation, in my op	e, date and place inion, death occ	e, and due to the ca urred at the time, da	use(s) and man ate and place, ar	ner as stated nd due to the	cause(s)
To	To	¥	29b. Signature and title of dertifier	/V4		29c. License OCM			ed. Date signed August 2		
CR	(2)		5, R, HOG	eted dause of death (Item 2)	3a) (Type, F 111	Penn St	reet, Ba	altimore,	Marylar	nd 2120	)1
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 7 2004	2. Registrar's Signatur		2					
онмн 1	7 Rev 1/20	001			1						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** 0315 Dennis Moore /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ALLEGAN umberland Meart sacred DITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 3, 1914 5. Social Security Number 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1**∑**M 2□ F Yrs. Director 112-32-8709 89 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, The Medical Examiner must be notified at once. Allegany MD Cumberland 1√ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Baltimore Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3 ☐ Widowed ♣ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher **Evans Adult School** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Cuthbert Moore Estella May O'Neal Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **Thomas Moore** brother 11015 Marty Street NW Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place)
Restlawn Memorial Gardens 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 9/6/2004 LaVale MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Lice 108 Virginia Avenue: Cumberland, MD 21502 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resciratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner been signed by the attending physicien end should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>À</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t lirector, page 2 s 2 No 1 TYes Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 1 Tes Certification: To 2**₽** No 1 Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide o the Hospital 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier ble mbe nua ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed RIVE Cumberland Mehann 32. Re strar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** BARAEL MARTINEZ Year 1258 AUUUST 2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BETHEON MOUTGONEY 8. Date of Birth (Month, Day, Year) 11/15/1958 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) El Salvador **Funeral** Months 1 **∑**M 2 □ F Director 214-33-0037 Yrs. 45 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Exertire Finant by India 31 ance. MD Prince George's Beltsville Completed by Funeral Director 1 ☐ Yes 2 No 10f, Zip Code 10g. Citizen of What Country? 11455 Cherry Hill Road #204 20705 El Salvador 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Tes 2 No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2□ No Specify: White Specify 3 Widowed 4 Divorced El Salvador 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House Cleaning Cleaning Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Estevan Gonsales Maria Martinez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 7 0 5 Anna Martinez/Sister 11455 Cherry Hill Rd.#204 Beltsville,Md 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 8/26/04 Silver Spring, Md \* 4 □ Donation 5 □ Other (Specify) 21. Signature PHTLTPAdos RIWALDI FUNERAL SERVICE, PA 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part I. Enfer the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTBAIOSCUSROTIC CARDIOUNSCULLAR DISCHASE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Dire to (or as a nonsequence of) that initiated events resulting in death) Last Due to (or as a consequence of): ८|२०|०५ , २३५१ Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 2 this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? Director: After 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funerai I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the the 29b. Signalure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ONE D15236 MO. AUGUST 21,2004 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PIRE, ROCKVILLE, MO COPSE MARGOLE, MA 11125 Bockwill T. 32. Fegistrar's Signature 31. Date filed (Month, Day, Year) State 25 2004 Registrar

Martinez

		II	1 - For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygie	21101.	2870f
153	Physic /Medi	cal	Decedent's Name (First, Middle, Last     MARY      Facility Name (If not institution, pice)	ANN	MATTHEWS	AUGUST 2	Day Year 2,2004	3. Time of Death 7:30 A M
	Examir Funeral	ner	4a. Facility Name (If not institution, give 4810 SUNDOWN ROA  5. Social Security Number 6. Se	D x 7. Age (In yrs, last birthda	4b. City, Town, or Location of Death LAYTONSVILLE  y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death MONTGOM  9. Birth	
	Director		220 58 8658  Usual Residence of Decedent  10a. State  10b. County	M 2XF 54 Yrs.	Months Days Hours Min.	March 19	1950 Wash	ington, D.C.
	the Maryl 28e-f sho	rector	Md. Montgo		omery Village	100	Citizen of What Cou	1 ☐ Yes 2 StNo
	eath with	Funeral Director	18621 Walkers Cho		20886	U	nited Sta	tes
9000	within 72 hours after death with the Maryland ane. than "netural", or items 23e or 28e-f show the Medical Evenithet.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces?  1 □ Yes 2 M No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert     □ Yes 2 S No Specify:	pecify Yes of No- o Rican, etc.)	14. Race - Ameri Black, White, Specify:	
Maryland 21215-0036	be filed within 72 hours after death with the Marylar tal Hygiene. d other than "netural", or Hems 23e or 28e-f show evant, it a Medica Executations to be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	(Giver in the completed) (Giver in the completed) (Giver in the completed)	edent's Usual Occupation ve kind of work done during most of wor . DO NOT use retired)  INSETOR	king	atholic Co	,
yland	should be filed withir ind Mental Hygiene. s marked other than umatic evant, the Market in the Marke	To Be C		tanbro	Rosema	ne (First, Middle, Maid ry M.	den Sumame) Conners	
, Mar	and 2 sh salth and n 27 is m		James W. Matthews	s, Sr./Husband 48	iling Address (Street and Number or Ru 310 Sundown Road,	ral Route Number, Ci _aytonsvil	ty or Town, State, Zip 1e, Md. 2	20882
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If itam 27 is marked any injury of other treumatic en		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	position (Name of ematory or other place) S Cemetery 8/2		. Location - City or To rmantown,	
Bail	permit. Departr Importa any inji		21. Significant of Funeral Service Licens	M-00470		Laytonsvi	ome lle, Md. 2	20882
	Pnysician /Medical		23a. Paryl. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not en eause on each line.  AUTOMOSC LEVOTIC  Due to (or as a consequence of):	. 1	Ols Chis		Approximate Interval Between Onset and Death
8760,	cate be executed whysician and the burial-transit	dical Examiner	Sequentially list conditions, if any least insulations, if any least insulations, if any least insulation in a sequential resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):				
.O. Box 6	the death certific y the attending p iched for use as	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
<u>a</u>	sign d be	by	Part II. Other significant conditions cor	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
	The law ate has b page 2 sl	Completed				24a. Was an autopsy performed	prior to cor	psy findings available mpletion of cause of
	ing Physician After this certif uneral director	atlon: To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time Injury	ent 3 DOA Other: 4 Nursing Ho	th (Check only one) ome 5 Residence 28d. Describe how in		Husband's
Dİ	or the in the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Street City or Town, Sta	ate)	·
	To tha Hospital or At within 24 hours after or To tha Funaral Dirac completely filled in by	ledical	one) 2/2 Medical Examil	sician: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stand place, and due to	ated. the cause(s)
	with Von	Σ	29b. Signatul e and title of certifier	- mo., (one)	29c. License number O\S\2 c		Date signed (Month, L	
			CARL Z. MARGOLI	mpleted cause of death (Item 23a) (Type 5, ma IH25 Pockrius 9	· ·	851		
	Sta Registr	61	31. Date filed (Month, Day, Year) AUG 24 200	32. Registrar's Signature	Sparks	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician JIMMY** C. MIDDLETON **AUGUST** 18, 1:18 PM 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deeth Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 2-24-69 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours **Ж**М 2□ F 579-82-4406 35 Yrs. Wash. DC Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. Charles Waldorf Director 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11743 Torcello Court 20601 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married Married 1 □ Yes 2 No If Yes, Give 1 Yes 2 No Specify: þ Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer System Tech. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jimmy Middleton Peggy Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Talease Middleton/Wife 11743 Torcello Ct. Waldorf, Md. 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Resurrection Cem. 8/25/04 Clinton, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility The House of Williams Funeral Service Es. 4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition END STAGE RENAL DISEASE resulting in death) Due to (or as a consequence of): HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown

Physician /Medical **Examiner** 

**Funeral** 

Director

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permit. Page Department o Important: If any injury or.

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the Medical Examiner must be notified at

with the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

P.O. Box 68760

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Division of Vital of market

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use as the burial-transit and the attending physician signed by þ Completed peen certificate has or Attending Physician: Be ို this in by the funeral Certification; After death. Director within 24 hours after of To the Funeral Direct completely filled in by

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ON HEMODIALYSIS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes 2 🔀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Mannef of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Whatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 23 2004

Shantha K.

29b. Signature and title of certifie

Murthy, M.D. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6196 Oxon Hill Rd. S-240

29c. License number

24064

000

29d. Date signed (Month, Day, Year)

Oxon Hill,

Md

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			1 - For State Registrar	ate of Maryland / [	Department of F Certificate of			iene	2870	18
	Dhuaisi		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h - V	3. Time of	Death
	Physici: /Medic		Jose Felix	Molina			August	_		рм
	Examin	er	4a. Facility Name (If not institution, give street	and number)	4b. City, Town, o	r Location of Death		4c. County of	Death	
			2203 Calvert Str			sville   If Under 24 Hrs.			George's	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bird	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State of Country)	or Foreign
	Director		217-80-3693 Usual Residence of Decedent	90			Aug. 11	, 1914	Chile	
	yland Now		10a. State 10b. County	10c. City, Town	or Location			<del></del>	10d. Inside Ci	ity Limits
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	h the	Director	10e. Street and Number	30 0 11700	10f. Zip Code		10	0g. Citizen of Wh	at Country?	
	23e c		2203 Calvert Street		2078:	3		Chil	.e	
	be tiled within 72 hours after death with the Maryland ital Hygiene. dd other then "naturel", or Items 23e or 28e-f show event, if e Medical Evenil at mint be notified in	Funerai		as Decedent Ever in U.S. med Forces?	13. Was Decedent of H If Yes, specify Cub.	lispanic Origin? (Spe	ecify Yes or No-		American Indian, White, etc.	
õ	or It	Fu	1 Never Married 2 Married 1	]Yes 2∱∏No ∕es, Give		Specify: Chil				
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N D	e filed within al Hygiene. other then '		17. Father's Name (First, Middle, Last)		raimer	18. Mother's Name	(First Middle A	Agricu	lture	
Maryland	ontal ed o	Be c	Jose Molina				Salina	,		
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Z	d 2 s th an th an trau		Blanca Lucy Molina/		203 Calvert			-		
	1 an Heal Heal		20a. Method of Disposition	20b. Place of	Disposition (Name of	, D	ate	20c. Location - Ci		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evonce.		1 Burial 2 Cremation 3 Remove	al from State Cameter Gate	y, crematory or other place of Heaven	1 -	t 28,		,	
	artme ortan njury		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Ce	emetery 22. Name and Addre		004 s	ilver Sp	ring, Mar	yland
n	Depi Impo			$C_{\alpha}Q_{\alpha}$	Francis J.	Colline	Funeral	Home In	c.	
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. Do n	500 Univer	sity Blvd	r respiratory arre	Silver S	pring, MD	2090
	95,		shock, or heart failure. List only one bau Immediate Cause (Final	se on each line.		<b>3</b> ,			Interval Bets Onset and D	ween Death
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	Examiner			Oue to (or as a consequence of						
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л Э	by tac	hys	9 □ Unknown	JUNKNOWN						
		by F	Part II. Other significant conditions contributi	ng to death but not resulting in	the underlying cause giv	en in Part I.	23e. Did tob	acco use contribu	ite to the cause of d	eath?
Ö	·= 0 0	ed	Recurrent Diverticu	litis, Weight	Loss		1 □ Ye	s $2 \frac{1}{\mathbf{x}}$ No 3	☐ Probably 4 ☐U	Jnknown
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T	0 - 0	Eo					autopsy perform 1 Yes 2	ied? dea	r to completion of ca th? Yes 2□ No	ause or
VITAI	icien: Th certificate ector, paq	a	25. Was case referred to medical			26. Place of Death				
>	8 8 5	To B	examiner? 1 ☐ Yes 2 🙀 No Hospita	l: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Oth	er: 4 Nursing Hon	ne 5 🔀 Resider	nce 6 Other	(Specify)	
וס ר				Date of Injury (Month, Day Year) 28b. T	ime of 28c. Injur	y at 2		w injury occurred		
<u>Ö</u>	Attending r death. sctor: After by the fune	atic	2 Accident investigation			Yes 2 □ No				
DIVISION	l or Atter de Directo	tiflic	3 Suicide 6 Could not be determined 286	. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	2	8f. Location (Str. City or Town,		or Rural Route Numi	ber,
2	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Certification;								
	Hospital	edical	29a. Certifier 1 Certifying Physician: (Check only 2 Medical Examiner: O	To the best of my knowledge, in the basis of examination and	, death occurred at the tin	ne, date and place, a	nd due to the ca	use(s) and mann	er as stated.	1
	To the Hospital within 24 hours a To the Funerel C completely filled	ledi	one) ar	nd manner stated.						
	To with	Σ	29b. Signature and title of certifier	un lagi mo	29c. Licens	e number	29	d. Date signed (f	Month, Day, Year)	
•				۵. ۵	D24	720		August	25, 2004	
			30. Name and address of person who complete							
			Ravinder K. Rustagi		ndover Rd.,	Cheverly	, MD 207	85		
	Sta Registr	.30	31. Date filed (Month, Day, Year) AUG 26 2004	32. Registrar's Signature	9 Sparks					
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. Nd.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year MAZN 1100126 Aubus 2210 PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year, April 10, 1 1 ☐ M 2 🖾 F 46 Director Yrs 585-72-2931 1958 New Mexico Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location show 10d. Inside City Limits f Health and Mental Hygiene. item 27 Is marked other than "natural", or Items 23a or 28a-1 shov other traumatic event. The Medical Examinar must be notified at Directo 1 ☐ Yes 2X No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12908-G Churchill Ridge Circle 20874 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Ite Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Share Holder 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Rydex Investments 12 Relations Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roger H. Moore Eileen Lemley 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Davis/Husband 12908-G Churchill Ridge Circle, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. August 24, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Montgomery Crematorium 2004 Bethesda, Maryland Robert A. Pumphrey Funeral 300 West Montgomery Avenue 21. Signature of Funeral Service Licensee Rockville, Inc. M00198 20850-2805 Rockville, Maryland 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) Priysician MONTHS 10 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial. Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel de 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetel death for in the past 12 months?
1 Yes 2 No Month Dav Year 4□Pregnant at time of death 5 Other (specify) P.O. I ed by the a 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 5 has autopsy perform certificate 2X No 2 No 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death Check onl one Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Funeral Dir 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 9 DI Deou ame and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of M	arylar	nd / Depa	artment tificate	of He	alth and	d Mer	ntal Hygi	g. No. ) ( 0 1	
	Physici /Medio	al	Decedent's Name (First, Middle, Las     Frances Miller     4a. Facility Name (If not institution, give		1		Ab City T	um orl	ocation of Di	A	Date of Death Month Ugust	Day Year 28, 2004  4c. County of Dea	3:55 PM
	Examir Funeral Director	ier	Laurelwood Care	Center		last birthday) Yrs.	If Under 1	lkto Year I	n f Under 24 h		Date of Birth Month, Day, US 23,	Cecil	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	after death with the Maryland or Items 23a or 28a-f show offer invest be motified at	Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Ceci  10e. Street and Number  645 Knight Island  11. Marital Status  1 Never Married 2 Married	nd Road  12. Was Decedent Ever in U.S. Armed Forces? 1 1 Types 2 M No.				219 of Hisp Cuban,	anic Origin? Mexican, Pu	-	10	g. Citizen of What Co USA 14. Race - Ame Black, Whit	10d. Inside City Limits 1 ☐ Yes 2 🕍 No untry?
	be filed within 72 hours a Ital Hygiene. Id other than "natural", o evant, I're M. Jic. I Exer	Be	3 □ Widowed 4 🌣 Divorced  15. Decedent's Ed (Specify only highest grave) Elementary/Secondary (0·12) 7  17. Father's Name (First, Middle, Last) Charles Platt	5+)	16a. Deced (Give life. L	1 Yes 2 No Specify:  Ident's Usual Occupation kind of work done during most of workir DO NOT use retired)  18. Mother's Name  Marion				rst, Middle, M	Specify: 6b. Kind of Business:  Own Home aiden Surname)		
	iit. Pages 1 and 2 should artment of Health and Mer ortant: If Item 27 ia marks injury or other traumatlc b.	To	19a. Informant's Name/Relationship (Type, Print)  COLLEN Miller/Son  20a. Method of Disposition  1 M Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  19b. Mailing Address (Street and Number or Rura  634 Saude Ave., Essing  20b. Place of Disposition (Name of cemetery, crematory or other place)  Edgewood Memorial Park 9-1							Rural Ad Ngto Date 9-1-2	nute Number, PA 2004 G	19029 Oc. Location - City or Elen Mills	Town, State
	Pnysician /Medical Examiner	Examiner	202. Part 1. Enter the disease, or composition of the part failure. List only of the part failure. List only of the part failure. List only of the part failure. List only of the part failure. List only of the part failure. List only of the part failure failure. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in Jury that initiated events)	a	s a consequence	quence of):	er the mode of	rune monz of dying,	AVE.	OME, Br diac or re	INC • OOK have spiratory arres	2n, PA 190 st.	Approximate Interval Between Onset and Death
P.O. Box 68760,	that the death certificate be executed of by the attending physician and detached for use as the burial-transit	by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as d.  23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	e of pregna 2 Feta at time of c	ancy al death 3 death 5 death	Ectopic preg Other (spec	ity)	in Part I.		23e. Did toba	23d. Date of del Month	Day Year
Vital Records, P.O. Box aician: The law requires that the death cer certificate has been signed by the attendir riector, page 2 should be detached for use	v requ	e Completed	25. Was case referred to medical						Death (C)	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
Division of V	fter me	Certification: To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be 4 Homicide		of 28c. Injury at Work?  M 1 Yes 2 No 28f. Location (					idence 6 Other (Specify) how injury occurred  (Street and Number or Rural Route Number,			
۵	To the Hospital or Attandii within 24 hours after death. To tha Funeral Diractor: A completely filled in by the fu	edical										ise(s) and manner as e and place, and due	to the cause(s)
	To the comp	M	29b. Signature and title of certification of the signature and address of berson who describes a signature of the signature o	completed cause of	death (Iter	п 23a) (Туре,	D		73			30AUG	
	Sta Regist		Acle 5702E,	32. Regist	Par's Signa	CITURCI	Thans	C	enter	_ \	kw (45	THE DE	19720

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer **Physician GERTRUDE** MARSHALL AUGUST 30 2004 3:40A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8281 LEONARDTOWN ROAD CHARLES HUGHESVILLE Months Days Hours Min. B. Date of Birth (Month, Dev, Yeer)

JUNE 16,1919 5. Social Security Number 6 Say 7 Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 X F Yrs MARYLAND Director 216-12-4344 85 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No CHARLES HUGHESVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours atter death with Innent of Health and Mental Hygiene.
snt: If Item 27 is marked other then "natural", or Items 23a or items or other traumatic event, It a Medical Examinat must be not 8281 LEONARDTOWN ROAD 20637 S. A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 WAITRESS RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LUTHER COPSEY GERTRUDE LONG ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AUGUSTA M. RUSSELL / DAUGHTER 8281 LEONARDTOWN ROAD HUGHESVILLE, MARYLAND 20637 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State SEPTEMBER Department of H Importsnt: If Ite any injury or of Burial 2 Cremation 3 Removal from State 3, 2004 TRINITY MEM.GRDNS. 4 ☐ Donation 5 ☐ Other (Specify) WALDORF, MARYLAND 22. Name and Address of Facility BRINSFIELD-ECHOLS FUNL. HME., P.A. permit. 21. Signature of Funeral Service Licensee Osa ory MO0641 30195 THREE NOTCH RD. CHARLOTTE HALL, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Die to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 ☐ Yes 2 ☐ No 3 Probably 4 Minknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? certificate 1□ Yes 2 7No To the Hospital or Attending Physician: tilled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No Hospital: Medical Certification; To 1 🗌 Inpatient 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Deat 28c. Injury at Work? 28d. Describe how injury occurred Atter 1 Natural 2 Accident 5 Pending investigation after death. 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a To the Funeral 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mp 5 0 0

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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32. Reg

2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day August Year **Physician** DONALD E. NABB 8:15 PM 22 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Elkton Cecil Union Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 11XM 2□F 68 221-20-8339 Yrs Director 12-3-1935 Delaware Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. Count r than "natural", or Items 23a or 28e-f show the Medical Example for most be notified at Middletown Delaware New Castle 1 ☐ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103A 19709 USA Berkman Street 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after day Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No white þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ing most of working Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor Manufacturing 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked oth eny injury or other treumatic event 2008. Helen Zacheis John R. Nabb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Hilliard 103A Berkman Street, Middletown, DE. 19709 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Townsend Cemetery 8-26-04 Townsend, DE. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DANIELS & HUTCHISON 21. Signature of Funeral Servi 212 N. Broad Street, Middletown, DE. 19709 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician HYPOXEMIA Sirely h /Medical Due to (or as a consequence of) Examiner DAT MENDENIAN HOLLOWIEL A Sequentially list conditions, any Lading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and thed for use as the burial-transit GENIVM Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy be detached for in the past 12 months? Day Year Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 15 Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 200 No ۴ 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 4- Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24.2064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DDUEN 0,0 106 BOW STATET Dordan Propile ₫32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 5 2004 Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month August Day Year **Physician** SAMUEL ASIYA NDIYO Sr 4:32PN 26 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lanham Prince George's Doctors Community Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
OCT 7 1957 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Yrs. Director 46 Nigeria 577–13–7205 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f shov item 27 is marked other than "natural", or Items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at 1√ Yes 2 No Directo Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 13820 Carlene Drive 20772 Be Completed by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: B1ack 3 Widowed 4 Divorced al Hygiene. other than "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Self employed permit. Pages 1 and 2 should be file Department of Health and Mental Hy, importent: if tem 27 is marked othe any injury or other treumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Alice A. Ndiyo Asiya Eyo Ndiyo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13820 Carlene Drive Upper Marlboro, MD 20772 Eneanwan Isok Ndiyo (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery 9-8-04 ` 4 ☐ Donattion 5 Ø Other (Specify) Clinton, MD Fugeral Service 22. Name and Address of Facility 22. Name and Address of Facility
4433 White Pls. Eberwein Funeral Services
La. White Pls., MD 20695 M00173 truck 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Pnysician disease or condition resulting in death) /Medical Examiner Spiration Sequentially list conditions, if any, leading to initial data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit law requires that the death certificate be executed tepalic Due to (or as consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? res 2 No 1 ☐ Yes or Attending Physicien: funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 746892 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7202 Quisinberry Way, Bowie, MD20720 TELELE MD. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 130pm **Physician** Ruth Elizabeth Nichols 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crescent Cities Center Riverdale Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 4/2/08 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 □ F 96 Yrs 216-22-1330 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Riverdale Md. P.G. 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 4409 East West Highway 20737 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give 1 XNever Married 2 Married Black 1 ☐ Yes 2 No Specify: Specify Completed by 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 7th and Mental Hygiene. College (1-4or 5+) Domestic Worker Private Homes 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Blake Charles Nichols 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty A. Andrews/Daughter 6216 Foote St., Seat Pleasant, Md. 20743 itam 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If its any injury or ot once. 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State 8/28/04 \* 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park Landover, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
H. S. Washington & Sons Co., Inc. anc 4925 Burroughs Ave., N.E., Wash., D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ArTeriosclenote Cardiovascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the aid to be detached for 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cate has been sig 24b. Were autopsy findings available prior to completion of cause of death?
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2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01852 o completed cause of death (Item 23a) (Type, Print) EVONE MI 4 703 Wisensbury & Hyatpullo and 20081

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 2 7 2004

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

2. Registrar's Signature

			1 - For State Registrar	State of Maryland	•	rtment of Hatificate of L		, ,	jiene 1eg. No	01-00715		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Cecil	Ambrose		Palmer		2. Date of Dea Month	Day	Year 3. Time of Death Year 11:30 A		
	Examir		4a. Facility Name (If not institution, give :  Bedford Court Nur			4b. City, Town, or Silver	Location of Dea Spring If Under 24 Hrs	th	4c. County			
	Funeral Director		5. Social Security Number 6. Sec 529 12 9825		birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min		1	9. Birthplace (State or Foreign Country) Misouri		
	Maryland a-f ahow	tor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montgom	10c. City, T	own or Lo					10d. Inside City Limits 1 ☐ Yes XXNo		
	h with the 23s or 28	al Director	10e. Street and Number  3709 Munsey Street			10f. Zip Code	0906	1	10g. Citizen of What Country?			
920	i within 72 hours after death with the Maryland liene. r than "natural", or Items 23c or 28a-f ahow the Wedical Exam artivust be undfiled at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates: WW II	1	Vas Decedent of His Yes, specify Cubar	spanic Origin? (	Specify Yes or No- rto Rican, etc.)		e - American Indian, ck, White, etc.		
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<b>Maryland</b>	o d in b	To Be C	17. Father's Name (First, Middle, Last)  James Henry Palmer				Sara El	me (First, Middle, I	lo1f			
	1 and 2 shi Health and Im 27 Is m		19a. Informant's Name/Relationship (Ty  Daisy Jean Palmer  20a. Method of Disposition	/ Wife	3709 e of Dispos	g Address (Street a  Munsey St  sition (Name of pactory or other place	reet Si	lver Spri	ing, Mar	State, Zip Code)           y1and 20906           City or Town, State		
Baltimore,	permit. Pages Department of H Important: If ite any injury or of		Description   2 □ Cremation   3 □ F    '4 □ Donation   5 □ Other   Specify    21. Signature of Funer   Lenfor Licens	Gate	22	Name and Address	s of Facility <b>Hi</b>	nes Rinal	ldi Fune	Spring, MD		
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18760,	/Medical Examiner  bhysician and the bruial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unised Section 1997 that initiated events resulting in death) Last	Due to (or as a consequent Diabetes Me1 Due to (or as a consequent Due to (or as a consequent	litus ce of):	5				5 Years		
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Division	P Sir D	Certification:	3 □ Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)			City or Towr	n, State)	er or Rural Route Number,			
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	one)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death and/or inv	estigation, in my op	inion, death occ	urred at the time, di	ate and place, a	and due to the cause(s)		
•	To t To t	Σ	29b. Signature and title of certifier	2		29c. License	5045	2		23, 2004		
	5		30. Name and address of person who co			od Court	#204 O1	nov Mar-	zland 2	20832		
	Sta Regist		31. Date filed (Month, Day, Year)	32. Hegistrar's Signature	19	Spork		ney, riary	rang Z	.UUJL		

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_			Registrar  1. Decedent's Name (First, Middle,	2. Date o					Reg. No.						
	Physici	an									Month	Day			
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	Maryland -f show flvd at		10a. State 10b. County		10c. (	City, Town or Lo	ocation							100	d. Inside City Limits
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	288 288	rec	10e. Street and Number	olough		Tampa	10f. Zip	Code				10g. Cit	izen of What	Countr	y?
	With Ba or	Ö	13610 Friar Pla	300			33	625				T			
	hours after death with the Marylar tural; or items 23a or 28a-f show al Exprilited at	Funeral Director	11. Marital Status	12. Was De	cedent Ever in	U.S. 13.	Was Deced	dent of Hi	spanic Orio	zin? (Speci	ify Yes or No-	Ira	11. Race - A	mericar	n Indian,
	iter of iter	Fu	1 ☐ Never Married 2X Marrie	Armed F	orces? 2 🛣 No		If Yes, spec	offy Cuba	n, Mexican,	, Puèrto Ri	can, etc.)		Black, W	hite, et	C.
336	es co	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	aive		1 🗌 Yes	2 A No	Specify:				Specify:	Whit	:e
21215-0036	"natural",	Completed	15. Decedent			16a. Dece	dent's Usua	al Occupa	ation			16b. K	ind of Busine	ss/Indu	stry
15	nin 7.	pie	(Specify only highes: Elementary/Secondary (0-12)	T	(1-4or 5+)	(Give	kind of wo DO NOT us	rk done d se retired	luring most )	of working	'				
212	r tha	Eo	Elementary/Secondary (0-12)	4	(1-401 5+)	Ow	ner					Рe	rsian	Rug	S
ğ	Hyg othe ent,	a	17. Father's Name (First, Middle, L	ast)					18. Mother	r's Name (	First, Middle,				
Maryland	id be ental Ked	To B	Mahmoud Payrow						Ma1	ek Ta	ı i				
2	Shound M mar mar	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address	(Street a			Route Numbe	er, City o	or Town, State	e, Zip C	ode)
Z	ith all		Nooshin H. Payı	cow/Wife		1361	O Eri	ar P	1200	Tamt	a, Flo	orid	2 336	25	
ā,	Hea Hear tern		20a. Method of Disposition	OW/ WIIC	20b	. Place of Dispo	sition (Nar	ne of		Da	te	20c. Lo	ocation - City	or Tow	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Mudical 2003.		1 Burial 2 Cremation			cemetery, cre			1 🕰	ugust		Tho	notosa	ssa,	,
臣	it. Puritme		* 4 □ Donation 5 □ Other (Sp. 21. Signatore of Funeral Service L		5	unset M				200			rida	Fun	owal Homo/
Ba	Depa mpo mny i		21. Signature of Fulleral Sevice D	(	140	0100   1	ethes	da-C	hevy	Chase	Inc.	75	57 Wis	cons	eral Home/ sin Avenue
			23a. Part1. Enter the disease, or	nom-linations that									1		pproximate
			shock, or heart failure. List of	only one cause on	each line.	Baut. Do not en	ter the mod	o or dymi	g, such as t	cardiac or	espilatory at	1031,		l l	nterval Between Onset and Death
	nysician	i	Immediate Cause (Final disease or condition resulting in death)			lerotic	Card	iova	scu1a	r Dis	ease				
	/Medical Examiner	Due to (or as a consequence of):													
	_ xummer	_	Sequentially list conditions,	b										4	
	ps is	Examiner	if any, leading to immediate	Due to	o (or as a cons	equence of):									
	be executed ician and burial-transit	am	Cause (Disease or injury that initiated events resulting in death) Last	c											
8760,	cate be execut physician and the burial-trar	Ē	rosaning in odalin) cast	Due to	o (or as a cons	equence or):									
376	cate be ex physician the buria	dicai		d										-	
		Med	IF FEMALE:												
Вох	death certific e attending p id for use as	an/l	23b. Was decedent pregnant	23c. If yes, o	utcome of preg birth 2  Fe	gnancy etal death 3[	∃Ectopic pr	egnancy					23d. Date of		
Щ.	0 0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time o		Other (sp	ecify)					Month	D.	ay Year
P.0	that the de led by the a detached t	hy	9 🗌 Unknown												<del></del>
S,	requires that the een signed by th hould be detache	by Physician/Me	Part II. Other significant conditio	•		esulting in the u	nderlying c	ause give	en in Part I.						cause of death?
p	w require been si should l	ed	Diabetes, Hyp	ertensio	n						1 U Y	'es 2	□ No 3 □	Probab	ly 4 ∏Unknown
Vital Records,	- D 70	Completed									24a. Was		24b. Were	autops	y findings available
æ	: The law cate has b page 2 sl	Elo							-		autop perfor	rmed?	death	?	oletion of cause of  ☐ No
ta		0	25. Was case referred to medical						26. Place	of Death (	Check only o		1 101	03 21	
	Physician: this certific ral director,	0 8	examiner? 1 AYes 2 □ No	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 DC	Othe			5 ☐ Resid		6 X Other (S	necity	lace of
		$\vdash$	27. Manner of Death		e of Injury onth, Day Year)			8c. Injury Work			d. Describe h			DOOM / P	usiness
on	Attanding F r death. ector: After by the funer	tio	1 X Natural 5 ☐ Pending 2 ☐ Accident investig		ntn, Day rear)	Injury	м		<br Yes 2∐1	No					
İS	Attaner death	fice	3 ☐ Suicide 6 ☐ Could n	ned 28e. Plac	ce of Injury - At	t home, farm, st	reet, factory	, office		28				Rural F	Route Number,
Ö	Direct of the property of the	Certification:	4  Homicide	buil	ding, etc. (Spe	icity)					City or Tow	m, State	)		
	Hospital or Attandi 44 hours after death. Funeral Director: A tely filled in by the fu	ai C	29a. Certifier 1□ Certifying	Physician: To the	ne best of my k	nowledge, deat	h occurred	at the tim	e. date and	d place, an	d due to the o	cause(s)	and manner	as stati	ed.
	e Hos 24 ho e Fun letely	edicai		xeminer: On the											
	To the Ho within 24 I	Me	29b. Signature and title of certifier				290	c. License	number			29d. Dat	te signed (Mo	nth, Da	y, Year)
	- 51-8		· In	$\sim$	10	(D)	10)	D154	226				4.0		0.4
	>			de completed ==	V V			D152	430			Augu	ıst 18,	, 20	104
			30. Name and address of person v						O D41-	o n	olered 1.1		1 - m 1	1	20052
	- 04		Carl I. Margol 31. Date filed (Month, Day, Year)		Begistrar's Sig	, 11125	KOCK	V ТТТ.	e rik	e, KO	CKVIII	e, N	ıary⊥aı	nd_	20852
	Sta Registi		AUG 25	2004	enera		100	uks.	/						

			1 - For State Registrar	State of Mary		artment of F rtificate of		, ,	iene	+ 28717
	Dhysiai	an	1. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month	Day Y	3. Time of Death
	Physici /Medio		Alvin B. Pec			1 .		August 1	9, 2004	5:50 A. M
	Examir	er	4a. Facility Name (If not institution, gr				r Location of Deat	th	4c. County of	
			Mariner Nursing 5. Social Security Number 6.		yrs. last birthday)	Betheso	I a  If Under 24 Hrs	8. Date of Birth	Montgo	mery  Birthplace (State or Foreign
	Funeral Director		578-16-2325	1 M 2□F 8		Months Days	Hours Min		1916 W	Country) ashington, D.C
			Usual Residence of Decedent			· · · · · · · · · · · · · · · · · · ·				
	nylan show	_	10a. State 10b. County		c. City, Town or Lo					10d. Inside City Limits
	Ba-1 s	cto	Maryland Montgo	mery	N. Bethe					X□Yes 2□No
	vith th	Directo	10e. Street and Number		.0	10f. Zip Code 20852		10	ng. Citizen of Wha	
	s 23	erai	5809 Nicholson I	12. Was Decedent Ever			lienania Origina /	Pageity Vac or No-	U. S.	American Indian,
36	a within 72 hours after death with the Maryland Jone. r than "natural", or Items 23a or 28e-f show the Macical Examinar must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  Married Forces?  Married Forces?  Married Forces?  No A  If Yes, Give  Year or Dates: WW	rmy	1 ☐ Yes 2 ☐ No	Specify:	Specify Yes or No- to Rican, etc.)		White, etc.
9500-61212		ted	15. Decedent's l	Education	16a, Dece	dent's Usual Occup	pation	1	16b. Kind of Busir	
213	filed within 72 Hyglene. Ither than "na! ant, the Madic	Completed	(Specify only highest g	College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wo d)			
7	od wit	Con	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3 Years	Rea	1tor			Real Est	ate
Maryland	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygles Important: It Item 27 is marked other it any injury or giber traumatic event, Im once.	To Be (	17. Father's Name (First, Middle, Las Nathan Peck	it)				me <i>(First, Middl</i> e, <i>M</i> es Schwar		
a	should have		19a. Informant's Name/Relationship		19b. Maili	ng Address (Street	and Number or R	ural Route Number,	City or Town, Sta	ite, Zip Code)
Σ	and 2 aalth n 27 I		Stella Hoffman l		- OFF		n Lane,			esda,2 <mark>Md</mark> 52
<u> </u>	S T T T		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3.		Ob. Place of Dispo cemetery, crei	matani or other olai	ce) 1 0		Oc. Location - Cit	
Ē	Pag ment tant: jury c		`4 ☐ Donation 5 ☐ Other (Spec	city) K				/22/2004	ralls Un	urch, Virginia
Battimore,	permit Depar Impor any in		21. Signature of Funeral Service Lice	. Stotte.	nyer_1	170 Rocks	-Goldber ville Pi	g Memoria ke, Rockv	ille.,Ma	s, Inc. ryland 20852
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that caused the y one cause on each line.	denth. Do not ent	ter the mode of dyin	ig, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Corona	y Artery	Disease				Onoot and Doam
	/Medical Examiner		resulting in death)	Due to (or as a co						
		_	Sequentially list conditions,	b. Prostat	te Cancer					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury	240 10 (0.43 4 00	mooquomoo orj.					- 2
	and al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as a co	insequence of):					
8/PU	cate be executed physician and i the burial-transit	dical		⊾ d.						
g	tificat ig phy as th	edi								
X Q Q	leath certific attending p	hysician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pour 1 ☐ Live birth 2 ☐		Ectopic pregnancy	,		23d. Date o	•
	dea he att	slcie	in the past 12 months?	4□Pregnant at time 9□Unknown		Other (specify)			Month	Day Year
r Ö	at the	Phy	9 Unknown					an- Pida-b		
Kecords,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	ed by PI	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.	1 Tyes		ite to the cause of death?  Probably 4 Unknown
ည္မ	e law re has be ge 2 sho	Completed						24a. Was an autopsy	, prio	re autopsy findings available r to completion of cause of
	The ate ha	Com						perform	ed? dea	th? Yes 2\ No
VItal	hysician: The la his certificate ha I director, page (a	Be (	25. Was case referred to medical examiner?					ath (Check only one	)	
0	Physician: this certific ral director,	은	1 ☐ Yes 2 😾 No	Hospital: 1 Inpatient	2 ER/Outpatier		4A Nursing F	dome 5 ☐ Resider		Specify)
	ath. or: After	ation;	27. Manner of Death  1 XNatural 5 ☐ Pending 2 ☐ Accident investigati		ar) 28b. Time o	Wor	yat k? Yes 2 □ No	28d. Describe how	w injury occurred	
DIVISION	al or Atters after de la Directo	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		At home, farm, str Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number o State)	or Rural Route Number,
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical (	29a. Certifier 1 X Certifying F (Check only one) 1 Medical Exa	Physician: To the best of maminer: On the basis of exa and manner stated.	mination and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occi	e, and due to the car urred at the time, da	use(s) and manne te and ptace, and	or as stated. due to the cause(s)
	To the To the To the To the Young	Me	29b. Signature and title of certifier	7	0	29c. Licens	e number	29	d. Date signed (A	Month, Day, Year)
	30			Comon!	Sou, m	DO	0571	24	8/1	9/04
	9		30. Name and address of person who				sda, Mary	71and 2081	17	f
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature 🍃					
	Regist	rar	AUG 2 3 21	004 Dem	0	Sparks				

·			1 - For Stete Registrar	State of Maryla		artment of F			jiene	001. 2071
	Dhysio	20	1. Decedent's Name (First, Middle, Last)					2. Date of Dear Month		8. Time of Death
4	Physici /Medi		Kenneth A.	Pels, Sr.					21, 2004	
4	Examir	ner	4a. Facility Name (If not institution, give s			4b. City, Town, o		ath	4c. County o	f Deeth
			Montgomery Genera  5. Social Security Number 6. Sex		la ad la indla da co	Olne	_	re la Data d'Bial	Montg	
ь,	Funeral Director			M 2□F 68	s. last birthday, Yrs.	Months Days	Hours Mi		, Year)	9. Birthplace (State or Foreign Country) Pennsylvania
	land ow		10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
	Mary -1 sh	ō	Md. Montgome	rv	Gai	thersburg	,			1 X Yes 2 □ No
	r 288	Director	10e. Street and Number			10f. Zip Code	<u> </u>	1	0g. Citizen of Wi	nat Country?
	th wit		21030 Goshen Road			208	382		USA	
	dea ems	Funerai	11. Marital Status 1	2. Was Decedent Ever in Armed Forces?	U.S. 13.			(Specify Yes or No- erto Rican, etc.)	14. Race	- American Indian, , White, etc.
21215-0036	172 hours after death with the Maryland *natural', or Items 23a or 28a-f show sdisal Examinet must be notified at	þ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ZYes 2 No 1	964-	1 ☐ Yes 2 ☐ No		sito i iloan, etc.)		White
5-0	72 h	etec	15. Decedent's Educ (Specify only highest grade		(Give	edent's Usual Occup s kind of work done	during most of w	rorking	16b. Kind of Bus	iness/Industry
121	within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)		II O A T	1
2	D 0 =		17. Father's Name (First, Middle, Last)	3	Atto	rney	19 Matharia N	ame (First, Middle, I	U.S.A.F	
ano	e = 0 ×	Be c	Anthony Pels				Lillia			,
Maryland	should by	은	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Maili	ing Address (Street		Rural Route Number		tate Zin Code)
	and 2 sealth ar n 27 is ser trau		Judith A. Pels/Wif					thersburg		
<u>6</u>			20a. Method of Disposition	20b.		osition (Name of omatory or other place		-		ity or Town, Stete
Baltimore,	D 0		1 ABurial 2 ☐ Cremation 3 ☐ Re  1 4 ☐ Donation 5 ☐ Other (Specify)					ent.3.04	Arlingt	on, Virginia
alti	mit. Pa		21. Signature of Funeral Serves License			2. Name and Addre			millingt	on, virginia
m	Depa Impo		Man A Sel		2	222 Wisco	rai Hom nsin Av	e.,NW.,Was	shington	DC 20007
*	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	Due to (or as a conse	ive	Heart		ure	<del>5</del> 51,	Approximate Interval Between Onset and Death
. Box 68760,	ne death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Medical Exa	resulting in death) Last	Due to (or as a conse	nancy lal death 3[	□Ectopic pregnancy	,		23d. Date Month	
P.0	that the ded by the detached	hys	9 Unknown	9□ Unknown					-	
Vital Records,	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions cont	ributing to death but not re	sulting in the u	underlying cause giv	en in Part I.	23e. Did tob		ute to the cause of death?  Probably 4 Unknown
900	e law re has be	Completed	Nan Insul	m Depe	ndert	Diabe	to Mell	autops	n 24b. We	ere autopsy findings available
<u></u>	The ate h page	E C	Chronic R	enal fa	ilure			perford	ped?   dea	or to completion of cause of ath? ] Yes 2□ No
/ita	ysicien: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?				26. Place of De	eath (Check only one	θ)	
of\	d S	은	1 ☐ Yes 2 ☐ No		ER/Outpatier		4 🗀 Nul Sing	Home 5 Reside	nce 6 Other	(Specify)
n C	ding F	ion	27. Manner of Death  1 Selection 1 Selection 1 Selection 2 Select	281 Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe ho	w injury occurred	
isic	Attending or death. ector: After by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At I	nomo form et		Yes 2 □ No	204 Leasting (Ct		
Division	Hospitel or Attend     Hours after death     Funerel Director: etely filled in by the	Certification:	4 Homicide determined	building, etc. (Spec	ify)			City or Town	, State)	or Rural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Euherel Director After th completely filled in by the funeral	Medical	one)	cien: To the best of my kn er: On the basis of examin and manner stated.	owledge, deat ation and/or in	ivestigation, in my o	pinion, death occ	curred at the time, da	ate and place, and	d due to the cause(s)
	To will	2	29b. Signature and title of certifier  Wilkinson	J. Nin	ala	D4	5285	- A	d. Date signed (	Month, Day, Year) 22, 2004
			30. Name and address of person who con	npleted cause of death (Ite	m 23a) (Type.	Print) 3 Wd #	113, 8	lver spi	ing, M	d 20901
1	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature /	1 ,		1	)/	

Registrar

AUG 25 2004 January

Ple	ase Type or Pri	nt in Black In	delible Ink	Fnsure Al	l Conies A	a Lani	hle
1-16	_	aryland / Depa			_	_	VIG.
For State	State of Mi				ieritai nygie	ne	
Registrar		Cei	rtificate of D	eam	Reg.	No.	14 28719
<ol> <li>Decedent's Name (First, Mid</li> </ol>	dle, Last)				2. Date of Death Month	Day	3. Time of Death
	CASSANDRA A	. PERRY	4h City Town or I	pacting of Dooth	August	20 8	004 244pm
4a. Facility Name (If not institut			4b. City, Town, or L			4c. County	
	COMMUNITY HOS		LANHA			PRINC	E GEORGES
5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday)		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		<ol> <li>Birthplace (State or Foreig Country)</li> </ol>
577-74-4927	1011112021	47 Yrs.			AUG. 25,	1956_	WASH. D.C.
Usual Residence of Decedent  10a. State 10b. Coun	h.	10c. City, Town or Lo	onting				10d Incide City Limits
Toa. State	Ly	loc. City, Town of Ec	Cation				10d. Inside City Limits
MD. PRIN	NCE GEORGES		HYATTSVILI	E			1X Yes 2 □ No
10e. Street and Number			10f. Zîp Code		10g.	Citizen of V	Vhat Country?
5229 KENTI	LWORTH AVE. A	PT. 202	2078	R1		II ·	S.A.
11. Marital Status	12. Was Decedent		Was Decedent of Hisp If Yes, specify Cuban,		ecify Yes or No-	14. Rac	e - American Indian,
1 ☐ Never Married 2X M	arried Armed Forces?	No			Hican, etc.)	Btac	k, White, etc.
3 ☐ Widowed 4 ☐ Divorc	If Yes, Give		1⊡Yes 2 <b>X</b> No	Specify:		Specify	BLACK
	ent's Education	16a Dece	dent's Usual Occupation	on.	161	Kind of Bu	usiness/Industry
(Specify only high	hest grade completed)	(Give	kind of work done dui DO NOT use retired)	ring most of work	ing	. And Or BU	on coorneadity
Elementary/Secondary (0-12	College (1-4or	5+)		) V/		OE OE	CMADTAT
12 17. Father's Name (First, Middle	lo I get)		SECRETAL		e (First, Middle, Mai		ETARIAL
17. Father's Name (First, Migdi	e, Last)		'	b. Mother's Name	e (rirst, Miladie, Mai	aen sumam	6)
JOSEPI	H WRIGHT				RUTH	W	YNN
19a. Informant's Name/Relatio	nship (Type, Print)	19b. Maili	ng Address (Street and	d Number or Run	al Route Number, C	ty or Town,	State, Zip Code)
THOMAS PER	RRY/HUSBAND	4347	CARMELO	DR., AN	NANDALE,	VA. 22	2003
20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place)		Date 200	. Location -	City or Town, State
1 ☐ Burial 2 X Crematio  1 ☐ Donation 5 ☐ Other	n 3 Removal from State		CREMATORY	8-28	2004	DTVEDI	MIE MD
21. Signature of Funeral Service							DALE, MD.
11916	hamlund	2 <sub>M00091</sub> CF 58	2. Name and Address IAMBERS FUN 801 CLEVEL	TERAL HO AND AVE.	ME & CREM , RIVERDA	ATORIU LE, MI	JM,P.A. D. 20737
23a. Part1. Enter the disease, shock, or heart failure. L	or complications that cause ist only one cause on each li	d the death. Do not ent ine.	er the mode of dying,	such as cardiac	or respiratory arrest,		Approximate Interval Between
Immediate Cause (Final	11	and the same of th	mondelp		Viene		Onset and Death
disease or condition resulting in death)	a. Due to (or as	a consequence of):	The state of	The same of	1 port		
	A - 7	LA & A.					
Sequentially list conditions, if any, leading to inmediate	b. Dua to for as	a nonsequence off:					-
cause. Enter Underlying Cause (Disease or injury	- San to for as	- same description.					
that initiated events resulting in death) Last	C						
1630iting in death) Last	Due to (or as	a consequence of):					
							1
	d						
	d					7	
IF FEMALE: 23b. Was decedent pregnant	d		-			23d. Dat	e of delivery
23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy	75-2		23d. Dat Mor	
23b. Was decedent pregnant	1 ☐Live birth	2 Fetal death 3					
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3 time of death 5	Other (specify)	in Part I.	23e. Did tobac	Mor	nth Day Year
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3 time of death 5	Other (specify)	in Part I.		Mor	nth Day Year
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3 time of death 5	Other (specify)	in Part I.	23e. Did tobac 1 ∐ Yes	Mor	nth Day Year
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3 time of death 5	Other (specify)	in Part I.	1 ☐ Yes 24a. Was an	More course control 2 No	nth Day Year  ribute to the cause of death?  3 Probably 4 Minknown
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3 time of death 5	Other (specify)	in Part I.	1 Yes  24a. Was an autopsy performed	More course contribute 2 No	nith Day Year  ribute to the cause of death?  3 Probably 4 Hanowr  Vere autopsy findings available to completion of cause of leath?
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown Part II. Other significant cond	1 □ Live birth 4 □ Pregnant a 9□ Unknown  iitions contributing to death b	2 Fetal death 3 time of death 5	Other (specify)		1 Yes  24a. Was an autopsy performed 1 Yes 2	More course contribute 2 No	nth Day Year  ibute to the cause of death?  3 Probably 4 Denknown  Vere autopsy findings availabil
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  Part II. Other significant cond  25. Was case referred to mediexaminer?	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown  itions contributing to death t	2 Fetal death 3 titime of death 5 but not resulting in the u	Other (specify)  nderlying cause given	6. Place of Deat	1 Yes  24a. Was an autopsy performed 1 Yes 2	More course contribution and the course contribution and the course contribution and the course cour	nth Day Year  ibute to the cause of death?  3 Probably 4 Menknowr  Vere autopsy findings available from to completion of cause of leath?  Yes 2 No
23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☑ No 9 □ Unknown  Part II. Other significant condesserved to mediexaminer?  1 □ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown  iitions contributing to death t	2 Fetal death 3 titime of death 5 but not resulting in the under the contract of the contract	Other (specify)  nderlying cause given	6. Place of Deat	1 Yes  24a. Was an autopsy performer 1 Yes 2 h (Check only one)  me 5 Residence	More course control 2 No 24b. V So 1	nth Day Year  ibute to the cause of death?  3 Probably 4 Definowr  Vere autopsy findings available reprint to completion of cause of leath?  Yes 2 No
23b. Was decedent pregnant in the past 12 months?  1	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown  itions contributing to death b	2 Fetal death 3 time of death 5 cut not resulting in the unterested to the cut of the cu	Other (specify)  nderlying cause given  2  at 3 DOA Other:	6. Place of Deat	1 Yes  24a. Was an autopsy performed 1 Yes 2	More course control 2 No 24b. V So 1	nth Day Year  ibute to the cause of death?  3 Probably 4 Definowr  Vere autopsy findings available reprint to completion of cause of leath?  Yes 2 No
23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant condes examiner?  1  Yes 2 No  25. Was case referred to mediexaminer?  1  Yes 2 No  27. Manner of Death  1  Matural 5 Pen 2  Accident	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown  itions contributing to death b	2 Fetal death 3 time of death 5 countries and set of the set of th	Other (specify)  nderlying cause given  at 3 DOA Other:  f 28c. Injury a Work?	6. Place of Deat	1 Yes  24a. Was an autopsy performer 1 Yes 2 h (Check only one)  me 5 Residence	More course control 2 No 24b. V So 1	nth Day Year  ibute to the cause of death?  3 Probably 4 Definowr  Vere autopsy findings available reprint to completion of cause of leath?  Yes 2 No

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one)

29b. Signature and title of certifier

2004

Director

Completed by Funeral

To Be

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

Priysician

/Medical Examiner

**Physician** /Medical

**Examiner** 

**Funeral** Director

29c. License number MDD 60545

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Item 23a) (Type, Print)
Main St, Suite 351, Laurel, Md 20707
Signature & Sparks of person who completed THE MINGO

31. Date filed (Month, Day, Year)

AUG 25 20 32. Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. (1) 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** Phillips Aug. 20, 2004 5:40p. Bessie Gwendolyn /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ade phi
If Under 1 Year III Under 24 Hrs. Prince George's Hillhaven Assisted Living Nursing & Rehab 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕅 F Months Director 013-05-2749 Usuel Residence of Decedent Feb. 13, 1918 Maine 86 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show or than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3483 Bruton Parish Way 20904 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after de ital Hygiene. d other then "natural", or Itams Black, White, etc. 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: δ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Secretary Carnagie Steel Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil ment of Health and Mental H tant: If Item 27 is marked otl Be John Farrell Ruby Crawford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health Important: If Item 27 any injury or other trong 3483 Bruton Parish Way, Silver Spring, Md. 20904 ace of Disposition (Name of 2000) Date 2000 Location City of Town, State Diane P. Riggs / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) \* 4 ☐ Donation Metroplitan Crematory Aug. 21, 2004 Alexandria, Va. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Rd. Beltsville, Md. Eward) ona 12 20705 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular Accident 1 month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the SS IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Month Day for 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a P.O. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by Poliomyelitis 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 ☐XNo 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 / Homicide within 24 hours at To the Funeral Completely filled i Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) August 21, 2004 29b. Signature and fittle of certifier 29c. License number D0036716 lucler more 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Kundrat, MD 8317 Cherry Lane
31. Date filed (Month, Day, Year)
32. Registrar's Signature Laurel, Md. 20707 State AUG 26 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Ν. Platt Robert 18, 2004 7:50 AM August /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 27, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 X M 2 □ F Yrs 211-38-6953 57 1947 Pennsÿlvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. fnside City Limits in then "natural", or items 23a or 28e-f show the Madical Examinar must be notified at 1 ☐ Yes 2 💢 No Completed by Funeral Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15107 Interlachen Drive, #1011 20906 United States Pages 1 and 2 should be filed within 72 hours after death anent of Health and Mental Hygiene.
snt: If item 27 is marked other then "natural", or items 23tary or other traumatic event, the Middell Examinal manual 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No If Yes, Give Dates Year or Dates: Unknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) 11 Grater Lumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles W. Platt, Sr. Madeline Ream 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly L. Platt / Wife 15107 Interlachen Drive, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) August 20, 2004 Montgomery Crematorium, Inc Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814—3501 M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Aspiration Pneumonia /Medical Due to (or as a consequence of): **Examiner** Multiple Sclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transil that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical use as the IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 🗌 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by ate has been signed page 2 should be 1 ☐ Yes 2 🛱 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to compfetion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 💢 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 

Inpatient 2 □ ER/Outpatient 3 □ DOA Other Certification: To 1 ☐ Yes 2 💢 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death 2 Accident 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours 29a. Certifier 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D27660 August 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11119 Rockville Pike, Rockville, Maryland 20852 Alpana Goswami, 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 23

DHMH 17 Rev 1/2001

Registrar

2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 07700 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician P M MARY POMERANCE AUGUST 17, 2004 3:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F Yrs. Director 338-03-3767 88 9, NOV. 1915 ILLINOIS Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be fliad within 72 hours efter death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or itams 23s or 28s-f show any injury or other treumatic event, the Modical Examiner must be notified at 1X Yes 2 ☐ No Directo MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11411 GRAYLING LANE 20852 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 BOOKKEEPER BOOKKEEPING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ **ADOLPH** DONINE FRIEDA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ALLEN POMERANCE/SON 7821 N. TRIPP AVE., SKOKIE, II 60076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 XRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) 08/20/2004 FOREST PARK, IL OKOJ CEMETERY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. manda 23a. Part1. Enter the disease, or complications that withed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a Insequence of): **Physician** Zuecks disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law raquires that the death cartificate be exacuted that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physicien by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 → No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 🗲 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name 10313 lan Schneider Olorgiu 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar AUG 23 2004

			1 - For State Registrar	State of	Maryland		artment of F				Reg. No.		28723
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Elizab	eth Jo	an Pur	cell			2. Date of Dea Month August	Day	2004	3. Time of Death  10:44 P M
	Examin		4a. Fecility Name (If not institution, give s		oer)		4b. City, Town, o	r Location of	of Death		4c. C	ounty of Deatl	h
			9409 Elsmere Court				Bethe		04 Usa			ontgome	
	Funeral Director		217-72-4192	M 2⊠F	. Age (In yrs. la	Yrs.	Months Days	Hours	Min.	8. Date of Birt (Month, Date Sept. ]	3, 19	9. Birth Co. Br.	nplace (State or Foreign untry) azil
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	Mary I sh	tor	Maryland Montgome	ry		В	ethesda						1 ☐ Yes 2X No
	th the	irec	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Co	untry?
	ath wi	ral	9409 Elsmere Cour	t				814				ted Sta	tes
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department or Health and Mental Hygiene. Department or Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itams 23a or 28a-f show important: If item 27 is marked other than "natural; or itams 27 is marked other than "natural Le molified at once.	by Funeral Director	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	2. Was Deced Armed Forc 1 Tes 2 If Yes, Give Year or Date	es? ⊠No	1	Vas Decedent of H f Yes, specify Cuba I □ Yes 2⊠ No	lispanic Ori an, Mexicar Specify:		cify Yes or No- Rican, etc.)		4. Race - Ame Black, White Specify: W	
21215-0036	72 hor	Completed	15. Decedent's Educ (Specify only highest grade	cation		16a. Deced	lent's Usual Occup	ation	t of working		16b. Kind	d of Business/I	
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4	tor 5+)		kind of work done OO NOT use retired		t of workir	ig .			
7	iled w lygier her th	Sol	17. Father's Name (First, Middle, Last)	2		Teach	er's Aid		or's Name	(First, Middle,	_		School School
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic avent, the Mer	To Be	Edward T. Purcell					M	argai	et Gar	vey		
Nar	12 sh n and r Is m raum		19a. Informant's Name/Relationship (Type Margaret G. Purce1			1	g Address (Street						
	1 and Health am 27 sthar tr		20a. Method of Disposition	1/Hotile	20h Ple	ace of Dieno	Elsmere	I.	-	ate		Ation - City or 1	
nor	Pages nent of I int: If it		1 XBurial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from St	ate Gat	metery, cren e of	natory or other plac Heaven	ce)   E		t 23.			ng, Maryland
Baltimore,	permit. F Departme Importan any injur		21. Signature of Funeral ServiceyLicense	e	M0019		. Name and Addre		ty			Bethe	sda-Chevy ase, Inc. -3501
2	Pnysician /Medical		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Metas	static	. Do not ente Breast	er the mode of dyin	ng, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death 1½ Years
	Examiner			Due to (or	r as a consequ	ence of):							
	uted I	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injuly	Due to (or	as a consequ	ence of):							-
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical Exa	that initiated events resulting in death) Last		r as a consequ	ence of):							
9	ntifica ng ph	Medi	IF FEMALE:	7.77							1		
O. Box		Physiclan/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		h 2∏Fetal∈ nt at time of de	death 3	Ectopic pregnancy Other (specify)				23	d. Date of deliv Month	very Day Year
α.	juires that t signed by lid be deta	by	Part II. Other significant conditions con	tributing to dea	th but not resul	lting in the ur	derlying cause give	en in Part I.			bacco use		the cause of death?
Vital Records,	The law requires that the ste has been signed by thoage 2 should be detached.	Completed								24a. Was a autop perfor	sy med?		opsy findings available ompletion of cause of
ita		BeC	25. Was case referred to medical examiner?					26. Place	of Death	(Check only or	2 ☑ No ne)	1 1 103	20110
ot	Phys r this ral di	2	1 ☐ Yes 2 ②No  27. Manner of Death	28a. Date of	natient 2 🗆 E	28b. Time of	28c. Injun	v at		e 5 🔀 Resid			ify)
ion	Attanding Ir death. actor: After	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year)	Injury	M 1 □	k? Yes 2⊡I	No				
Division	of or Attano after death Diractor: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined		f Injury - At hor , etc. <i>(Specify)</i>		eet, factory, office		2	8f. Location (S City or Tow		Number or Rur	al Route Number,
	To tha Hospital or At within 24 hours after of To the Funeral Diraci completely filled in by	edical C	29a. Certifier (Check only one) 1X Certifying Phys 2 Medical Examin	ician: To the b er: On the bas and hanne	is of examination	vledge, death on and/or inv	occurred at the tin estigation, in my o	ne, date an pinion, dea	d place, ar th occurre	nd due to the o	ause(s) ar late and pl	nd manner as a lace, and due t	stated. to the cause(s)
	To tha within 2 To the complet	Me	29b. Signature and title of certifier				29c. License			2	29d. Date s	signed (Month,	Day, Year)
)	<		1 X/W		>		D00	33293		4	Augus	t 20,	2004
	1,00	Ì	30. Name and address of person who con				•	u					
	· · ·		Frederick P. Smith 31. Date filed (Month, Day, Year)		5454 T gistrar's Signati	ure .	1		00, C	hevy Cl	nase,	Mary1a	and 20815
	Sta Registr	. • 3	AUG 2 3 2004		and a digital	5	Sporks	/					

			For State	State of Maryla	and / Depa	artment		th and M	•		9.0.0.	
			Registrar	1	Cer	uncate	OI Dea	<i>aui</i>		Reg. No.	AL.	28724
	Physici	an	Decedent's Name (First, Middle, Last						2. Date of Dea	Day	Year	-3. Time of Death
	/Medic		Clinton Jefferson			_			AUGUST	27	2004	10:30 P. <sup>™</sup>
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or Loca	ation of Death		4c. Cou	nty of Death	h
			VA MARYLAND HEALT	H CARE SYSTE	EM			POINT			CEC	IL
	Funeral		5. Social Security Number 6. Se	x 7. Age (In y	rs. last birthday)	If Under 1 Months		Inder 24 Hrs.	8. Date of Birt (Month, Da	h y, Yea <i>r</i> )	9. Birth	nplace (State or Foreign untry)
	Director		214 26 4533	7.	<b>5</b> Yrs.				May 29	,1929		lánd
	pu »		Usual Residence of Decedent  10a, State 10b, County	100	City, Town or Lo							104 (
	aryla shov	L.	10a. State 10b. County	100.	City, Town or Lor	cation						10d. Inside City Limits
	Ba-f:	cto	Maryland Cecil	No	rth East	:						1 X Yes 2 □ No
	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 Ia marked other than "netural", or Itams 23e or 28e-f show any injury or other traumetic event, it is Medical Examinational be notified at 20ce.	Director	10e. Street and Number			10f. Zip (	Code			10g. Citizen o	of What Cou	untry?
	th w	a	107 Walnut Street			2190	1			United	Stat	es
	dea	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13. V	Was Decede	nt of Hispani	ic Origin? (Sp	ecify Yes or No Rican, etc.)	14. F	lace - Amer Black, White	ncan Indian,
9	after or Ita		1 Never Married 2 Married	1 X Yes 2 □ No 1 If Yes, Give	951	1 🗆 Yes 2		ecify:	1 110211, 0(0.)			, 610.
8	ral',	by	3 ☐ Widowed 4 ♣ Divorced	Year or Dates: 1	953	1 U 165 2	<b>2</b> 140 3pt	өспу.		Spe	wh	ite
5-0036	72 hc	tec	15. Decedent's Edu (Specify only highest grad	ication	16a. Deced	tent's Usual	Occupation	most of work	ina	16b. Kind of	Business/l	ndustry
2	hin .	pje	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NDT use	retired)	most of work	"'9			
2121	d wit	Completed	9		Plumbe	r				Aberde	en Pr	oving Groun
D	otha otha	Be C	17. Father's Name (First, Middle, Last)		410.00		18. 1	Mother's Name	First, Middle,			
<u>a</u>	td be enta ked ic av	To B	Marshall Purner				Ma	rtha M	eekins			
Maryland	shound M	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailin	a Address (			al Route Numbe	r, City or Tou	vn. State. Zi	ip Code)
Za	d 2 s th ar t7 la		Ellen Cantler/Sis						h East,			
	1 an Heal		20a. Method of Disposition		o. Place of Dispos				Date	20c. Locatio		
Baltimore,	ges Fito or or		1X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, crem	natory or oth	er place)	Sent	1 2004	200. LOCATIO	ii - Oity Oi i	TOWN, State
Ë	Pa men ent:		' 4 ☐ Donation 5 ☐ Other (Specify)	-	Cem	netery				North		Maryland
ä	Departition Depart		21. Signature of Juneral Secrice I cens	*/ //	22	. Name and	Address of F	Facility Cro	uch Fun	eral H	ome	
0	80 5 5 8		Mobel A. C	Ince								land 21901
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the d	eath. Do not ente	er the mode	of dying, suc	ch as cardiac o	or respiratory ar	rest,		Approximate Interval Between
			Immediate Cause (Final		- 17-00-							Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. MALIGNAN		ASM OF	, PFEO	RA			-	6 months
	Examiner			Due to (or as a cons	sequence of):							
		L	Sequentially list conditions, if any, leading to immediate	b			_					
0.1	sit sit	ine	cause. Litter Underlying Cause (Disease or injury	Due to (or as a cons	sequence or):							
4	te be executed ysician and ie burial-transit	Examiner	that initiated events resulting in death) Last	с								
60,	be ex Ician a burial	ω .	in south, and	Due to (or as a cons	sequence or):						}	
	ate b nysic he b	ical		d								
89	certificate Iding phys	Med	a security									
Вох	es that the death certificate igned by the attending phy be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pre				23d. [	Date of deliv	,
	d for	icia	in the past 12 months?	4☐Pregnant at time of		Other (spe				1	Month	Day Year
P.O.	the ty the	λ	9 Unknown	9 Unknown								
	that ed b deta		Part II. Other significant conditions co	ntributing to death but not	resulting in the un	nderlying cau	use given in F	Part I.	23e. Did to	bacco use co	ontribute to	the cause of death?
S	sign sign d be	d by							1 🗆 Y	es 2□No	3 ☐ Pro	bably 4XXUnknown
Division of Vital Records,	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	Completed										
ec	law as b	ple							24a. Was autop	sy	prior to co	opsy findings available ompletion of cause of
<b>~</b>	The ate h	0							perfor		death?	2 🗆 No
a	en: rtifica tor,	(a)	25. Was case referred to medical				26.	Place of Death	Check only o			
>	ysici s ce direc	To B	examiner? 1 \sum Yes 2\sum No	Hospital:	ER/Outpatient	t 3□ DOA	Other: 4(	Nursing Ho	me 5 Resid	lence 6 $\square$ C	ther (Speci	ifv)
0	Physical of this		27. Manner of Death	28a. Date of Injury (Month, Day Year			c. Injury at Work?		28d. Describe h			
on	ding Afte fune	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	) Injury	м	Work? 1 ☐ Yes	2 □No				
S	ttan deat tor: the	ica	3 Suicide 6 Could not be	28e. Place of Injury - A	t home form etre			-	28f Location /9	treet and Nur	mber or Pur	ral Route Number,
.≥	or A litter Dirac in by	Certification:	4 Homicide determined	building, etc. (Spe	ecify)	set, tactory,	Office		City or Tow	n, State)	nbor or rigi	ar rioble rember,
	To the Hospitel or Attanding Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		<u> </u>								CW	
	t house funa	edical	(Check only 2 Medical Exam	sician: To the best of my liner: On the basis of exam	knowledge, death iination and/or inv	occurred at restigation, i	the time, da n my opinion	ite and place, : i, death occurr	and due to the o ed at the time, o	ause(s) and r date and place	manner as s e. and due t	stated. to the cause(s)
	tha I	ed	one)	and manner stated.								
	To To	Σ	29b. Signature and title of certifier	LAND		29c.	License num	nber	1	29d. Date sigr	ned (Month,	, Day, Year)
	,		•	11/10		D2	20215			8-27	7-04	
	4 0	1	30. Name and address of person who c	ompleted cause of death (I	tem 23a) (Tvpe. i							
1	0 111	KAI	RMACHANDRA NAIR, M.				ARE SY	STEM, I	PERRY PO	ידעד. א	ID 219	02
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si						/ 1		
	Registi		AUG 3 0 2004	Acres A	Some	0						
				The state of the	Put appear							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2004 11:30 aM 26, Margaretha Sofia Pouwels August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Residence: 1573 Liberty Grove Road Conowingo Cecil 8. Date of Birth (Month, Day, Year) Nov. 18,1922 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🖾 F Holland 81 213-38-6343 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ir than "natural", or itams 23e or 28a-f show the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Cecil Conowingo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21918 1573 Liberty Grove Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker Twelve Years other permit, Pages 1 and 2 should be file.
Department of Health and Mental Hy, important: If tiem Z7 is marked other any injury or other treasure. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hendrika Knol Gabriel Van der Veen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaretha T. Graybeal (daughter) 1577 Liberty Grove Road, Conowingo, MD 21918 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 08/30/04 Colora, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) West Nottingham Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. accepted 21903-0766 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). To the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 21K No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident the Director: 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of MIN NK, 166, NG, 2078 31. Date filed (Month, Day, Year) State 0 2004 Registrar

				State of Maryland / Department of Health and Certificate of Death	-	_	4 28726
		Physici /Medi		ODDDO C. FIIIIII FO	2. Date of De Month	Day Year	J I I I I I I I I I I I I I I I I I I I
		Ēxamir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De Riverside  4b. City, Town, or Location of De Riverside	amp		ord
(0		Funeral Director		5. Social Security Number 212–38–4610 6. Sex 1 Months Pays Hours M Pays Hours M Usual Residence of Decedent		1906 No.	irthplace (State or Foreign Country) rth Carolina
2	-	with the Maryland a or 28a-f show Le notified at	tor	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 💆 No
N. III.P.		ith with the 23a or 28i	Funeral Director	10e. Street and Number 101 Garfield Court 21078		10g. Citizen of What (	Country?
5		permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-1 show amy injury or other traumatic avant, the Medical Evantment for notified at once.	þ	If Yes, Give 1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No erto Rican, etc.)		
Ü	215-0036	within 72 hours after ane. than "natural", or its se Medical Exa⊤ire	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work done	vorking	16b. Kind of Busines	
8	and 21	d be filed w ental Hygier ced other th c avant, th	Be	17. Father's Name (First, Middle, Last)	lame (First, Middle he Currie	Public Sc Maiden Sumame)	hools
555	, Maryland	and 2 should is saith and Men n 27 is marke ler traumatic	To	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ulysses Currie / nephew  6621 Lacon Street, Fo	Rural Route Numb	er, City or Town, State,	
200	Baltimore,	Pages 1 ament of Hemont: If itam		20a. Method of Disposition  1 🛣 Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Arlington National 9/	Date 3/04	20c. Location - City of Arlington,	r Town, State Virginia
	Ball	permit. Departr imports any inji		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Lisa Scott Fune 552 Lewis Stree	ral Home, t, Havre	P.A. de Grace,	
		Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardishock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or ac a consequence of the content of the	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
Cup.		Examiner	ner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
	,0921	ite be executed lysician and ne burial-transi	ical Examiner	resulting in death) Last Due to (or as a consequence of):			
	P.O. Box 68760,	To the Hospital or Attending Phyaician: The law requires that the death certificate be executed within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown		23d. Date of de Month	elivery Day Year
	rds, P	en signed bould be deta	by	Part II. Other significant conditions continuous to death but not resulting in the underlying cause given in Part I.		obacco use contribute t ∕es 2 □ No 3 □ P	to the cause of death?
	of Vital Records,	: The law recate has be page 2 sho	Completed		24a. Was autop perfo 1  Yes		utopsy findings available completion of cause of
	Vit:	vician certifi rector	Be	examiner?	eath (Check only o		
	ion of	nding Physith. :: After this	ation; To	1   Yes   25 No   1   Inpatient   2   ER/Outpatient   3   DOA   Outpatient   2   Nursing   27. Manner of Death   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   2   Accident   investigation   M   1   Yes   2   No		lence 6 Other (Spenow injury occurred	ecify)
	Division	tal or Atter is after dea al Director ed in by the	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (5 City or Tow	itreet and Number or A n, State)	tural Route Number,
		the Hospi hin 24 hour tha Funar upletely fill	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and plant of the date of examination and/or investigation, in my opinion, death occurred at the time, date and plant occurred at the time, date and the time, date and the time, date and the	curred at the time,	date and place, and du	e to the cause(s)
				29b. Signature and title of certifier  29c. License number  29c. License number  29c. License number		29d. Date signed (Mon	in, Day, Year)
	_	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	116,20	78	
		Sta Registr	- 1	AUG 2 5 2004  32. Registrar's Signature	/		

			1 - For Amend Item	State of per	of Marylan Dr.,G83	d / Depa 5,09 <b>/1</b>	ortment of H	lealth and I <i>Death</i>	Mental Hyg	iene 9. No. 2004	1-28727
			Decedent's Name (First, Middle, L.					·············	2. Date of Deat Month	h	3 Time of Death
	Physicia /Medic		Albert George	Pierce					Äugus	t 22,200	1-1:20 <b>A</b> M
	Examin		4a. Facility Name (If not institution, gr 9 Brent Street	ve street and nu	mber)		4b. City, Town, o	r Location of Death	h	4c. County of Dea	
	Funeral		Social Security Number 6.	Sex	7. Age (in yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.		9 Bi	rthplace (State or Foreign
	Director		056-20-4773	1□M 2□F		79 Yrs.	Months Days	Hours Min.	May 25	,1925	N Y
	p ,		Usual Residence of Decedent  10a. State 10b. County		100 Ci	y, Town or Lo	cation				10d. Inside City Limits
	shov	5			100. 01						1 ☐ Yes 2 ☐ No
	the N	Director	MD Wash	ington		Hanc	10f. Zip Code		10	Og. Citizen of What C	^
	with Sa or	<u>ā</u>	9 Brent Street				2175	0		USA	,-
	death	Funeral	11. Marital Status		edent Ever in U	.S. 13. V	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - Am	
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23a or 28e-f show any injury or other traumatic event, I'm Medical Evantrer must be recitled at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed F 1 (X) Yes If Yes, G Year or I	2 □ No ive	1	f Yes, specify Cub 1 ☐ Yes 2 ☐ No	an, Mexican, Puert Specify:	o Hican, etc.)	Specify: WH	
Ö	72 ho	Completed	15. Decedent's I	ducation	1	16a. Deced	ient's Usual Occup	ation during most of wor	rkina	16b. Kind of Business	s/Industry
2	ithin Jan	nple	Elementary/Secondary (0-12)	College (	1-4or 5+)	1		during most of word)		0:1	
7	led w lygier her th		17. Father's Name (First, Middle, Las	4		Mar	keting_		ntative n <i>e (First, Middl</i> e, A		
ano	ntal H ed of ed of	Be	Lawrence V. Pi						e L. Bl		
Ž	should ad Me mark matic	ဥ	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street			City or Town, State,	Zip Code)
Σ	od 2 s lith ar 27 is r trau		Anna Jean Pie		fe		rent St			MD 2175	
ē,	s 1 and 2. of Health ar item 27 Is		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name of natory or other ple			20c. Location - City of	
Ë	Page nent o int: If iry or		1X Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Spec		State				8/25/04	Hancoc	k,MD
Balti	permit. Departrimporte any inju		21. Signature of Funeral Service Lie	Pesson	R.	- 1	Name and Addre	ss of Facility neral Hom	η 1.	41 West Ma	ain Street
ш	<u> </u>		1 Kick	V Q	0				<del> </del>	Hancock,	
			23a. Part1. Enter the disease, or co shock, or heert failure. List only	y one cause on	each line.	n. Do not ent	er the mode of dyl	ng, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. COPD							30 yrs.
Н	Examiner		1		(or as a consec		. D-6!-				10
		e	Sequentially list conditions, if any, leading to immediate	b. AIDD Due to	(or as a consec	ILLYDS juence of):	in Defic	Lency			10 yrs.
	d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
o,	cate be executed physician and the burial-transit	Exa	resulting in death) Last	Due to	(or as a consec	(uence of):					
8760,	ate be	dlcal	•	d		-					
9	entific ding p	/Med	IF FEMALE:	23c If yes o	itcome of pregn	2007				201 0 1 1	
Вох	that the death certificed by the attending properties as	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Feta nant at time of c	al death 3	Ectopic pregnanc Other (specify)	1		23d. Date of de Month	Day Year
o.	y the diched	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unki			Gunor (Speciny)				
<u>α</u>	The law requires that the death certificate has been signed by the attending I bage 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	ecco use contribute t	o the cause of death?
rds	w requires l been signe should be	ed b	ASHD CHF						1 □ Ye	s 2⊠No 3□P	robably 4 Unknown
Vital Records,	ie law requ has been ge 2 should	plet	Hypothyroidism						24a. Was ar		utopsy findings available completion of cause of
ž		Com							perform 1 ☐ Yes 2	ned? death?	s 2□No
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	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director, 1	edical (	29a. Certifier 1 Certifying F (Check only one) 1 Medicel Ex	miner: On the	e best of my kno basis of examina oner stated.	owledge, death ation and/or in	n occurred at the ti vestigation, in my o	me, date and place opinion, death occu	, and due to the ca irred at the time, da	use(s) and manner a ate and place, and du	s stated. e to the cause(s)
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			Fred B The	on DMI	9		D00	012237		08-24-04	<b>+</b>
	10		30. Name and address of person wh Frank B Thomas, I.	o completed cau	ise of death (Ite	m 23a) (Type, Nolowa		cock, MD	21750		
	Sta Registi		31. Date filed (Month, Day, Year) \$ EP 0 9		Redistrar's Signa		books		· · · · ·		

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ox 68760,	h certificate be executed	ending physician and r use as the burial-transit

Division of Vital Records, P.O.

Month Year **Physician** 10:25 PM 106051 23 YVONNE ELIZABETH PORTER 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** PRINCE GEORGES DOCTORS COMMUNITY HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2000 Yrs. Director 65 23, 1939 ILLINOIS 327 34 0947 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at XX Yes 2 No Director MARYLAND PRINCE GEORGES LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Івтя 23е 20706 UNITED STATES 5405 MARLENE DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married "naturel", or 1 ☐ Yes XX No Specify: þ Specify: BLACK XX Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) HOME MAKER DOMESTIC 4YRS. or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 UNK. WILLIAM JONES GERALDINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is in any injury or other treum <u>once</u>. 5405 MARLENE DRIVE LANHAM, MD 20706 LYNETTE PORTER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State • 4 □ Donation 5 □ Other (Specify) METROPOLITAN CREMATORY 25 AUG 04 ALEXANDRIA, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anoxu disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 res 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed (3) 2 No 1 🗌 Yes 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMJADI M.D. 575 MAINSTREET SUITE 351 LAUREL, AMIK ALT 31. Date filed (Month, Day, Year) AUG 2 7 2004 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1 - Stata Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death

		1 - For State Registr AMEND ITEM #	29d PER PI	IY G835 99	091094e 9H	Death	2. Date of De	Reg. No.	2 8 7 2 C
Physicia			/	מ מ	/CE		Month	Day Yea	ar, 1:1190
/Medic		MAIZE  4a. Facility Name (If not institution, give	street and number)	rĸ.		r Location of Dea	May	4c. County of D	
Examin	er	Montin Mar	105		Prince	ss Anc	10	Sam	piropt
Funeral		5. Social Security Number 6. Se	<del></del> .	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth av Yearl 9. I	Birthplace (State or Fore
Director		149-10-1/9/	□M 2 <sup>M</sup> F 1	03 Yrs.	Wortus Days	Hours	Dec. 1	2, 1900 V	irginia
<b>&gt;</b> 1200	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Lir
e P	ö	Maryland Somerset	r l	Princess					1 Yes 2
28a-f show	ect	10e. Street and Number		111110000	10f. Zip Code			10g. Citizen of What	Country?
ene. than "natural", or items 23a or 28a-1 show fra Madical Examination natibilish at	٥	11974 Edgehill Terr	ace		21853	₹		USA	,
if Health and Mental Hygiene. Itam 27 is marked othar than "natural", or Items 23a or 28a-1 shov other traumatic event, Itte Medical Experiment wat be rediffied at	by Funeral Director	11. Marital Status	12. Was Decedent 8	ever in U.S. 13.	Was Decedent of H		Specify Yes or No		merican Indian,
or ite	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖔 N If Yes, Give	0	1 ☐ Yes 2 No		to Hican, etc.)		hite, etc.
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and Menial Hygiene. Is markad other than "natural", or flems aumatic event, the Madical Exemple or	၉	19a. Informant's Name/Relationship (T)	vna Print)	19b Maili	no Address (Street			er, City or Town, State	Zin Code)
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Heal tam 2		20a. Method of Disposition	-	20b. Place of Dispe	osition (Name of	1	Date	20c. Location - City	
y or i	- 1	1 ☐ Burial 2 ☐ Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)		,	matory or other plac morial Ce	· 1	4/2004	Princess A	nne Maryla
Department of Health a Important: If itam 27 is any injury or other tra once.	i	21. Cignature of Funeral Service Licens	$\sim$					y Road - S	
Depa Impo any ir		Hatrus )	10 tol		OLLEY M			,	u,,
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within 24 hours after death.  To the Funaral Director: After this certifica completely filled in by the funeral director.	Med	29b. Signature and title of certifier  W & W  30. Name and address of person who ce		anh (lare 20 : T	B. D.	047090	1	MAY 21,200	14 2y MD 2480

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND

TIFM #20b PER FH C835 9/09/04 III
State of Maryland Department of Health and Mental Hygiene For WICHD, aq State Registrar Amend#19a.08-18-04, PerFH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Walter Month Year **Physician** 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death -4c. County of Death Examiner 2671 PG DAKS BRAGGERA 1520 Sunath Rd. Clinton nul If Under 1 Year If Under 24 Hrs. 8. Date of Birth NSG · Home Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 3 - 3 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 102M 2□F -14-3675 80 Director Usual Residence of Decedent 10a. Slate 10c. City, Town or Location t show 10d. Inside City Limits other traumatic evant, the Medical Examiner must be notified at Director 1≱Yes 2 □ No ASHINGTON JEDRGES 10e. Street and Number 10g. Citizen of What Country? or Itema 23e or )SA 2208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or ite 1 Yes 2 No Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. à BLACK 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be YOLK KHIMDND BIVENS HATTIE ant's Name/Relationship (Type, Print)
Sharon Polk 19a. Info 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, Slate 20a. Method of Disposition 2 Cremation 3 Removal from State 1 M Buria injury or S Bor. CA. CEM 8/14/2004 PRINCESS HONE MD.
22. Name and Address of Facility BENNIE Smith FIH MARY'S BOT. CH. CEM! 4 □ Donation 5 □ Other (Specify) 21. Signiture of Funeral Service Licyns any 917 W-ISABELLA ST. SALISBURY, MD. 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Duvi to for all a co. the attending physician and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P. 0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 🗆 No 1 ☐ Yes 2 7 1 Yes Division of Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: Other: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA In rsing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; 1 Natural 2 Accident Injury 5 Pending death. 1 🗌 Yes 2 No investigation within 24 hours after death to the Funeral Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29b. Signalure and title of certifier ddress of person who completed cause of death (Item 23a) (Type, Print) Date filed (Mo 32. Reg State Registrar

		1 _ State	Department of Health and Ment  Certificate of Death		- 45 I
		1. Decedent's Name (First, Middle, Last)		Reg. No	73. Time of Death
Physici		John Arthur Robison	N	Month Da	
/Medic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	71 0	C. County of Death
Lxamii	101	SACRED HEART HOSPITAL	Cumberland		ALLEGANY
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year   If Under 24 Hrs.   8. D.   Months   Days   Hours   Min.   (A	ate of Birth Month, Day, Year	9 Birthplace State or Foreign
Director		219-56-7565 <sup>1</sup> ♥ 2□ F 55			949Maryland
and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Tox	vn or Location		10d. Inside City Limits
Aaryl sho	ctor	Maryland Allegany LaVa	le		1 <b>X</b> Yes 2 ☐ No
the N	rect	10e. Street and Number	10f, Zip Code	10g. C	itizen of What Country?
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death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify ) If Yes, specify Cuban, Mexican, Puerto Rican		14. Race - American Indian,
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and 2 sl and 2 sl salth and n 27 ls r		Victoria Robison-Wife 7	07 LaVale Terrace, La	aVale,	MD 21502
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n gosaa		Sougho Stager	1302 National Hwy	vice, i .TaVale	MD 2150 mate
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I RECORDS, P.O. BOX 68 ( The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco  1/ Yes 2 24a. Was an autopsy performed?  1/ Yes 2/ No.	23d. Date of delivery  Month Day Year  use contribute to the cause of death?  I No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?
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To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physicient properties to the Funerel Director: After this certificate has been signed by the attending physicient properties of the funeral director, page 2 should be detached for use as the	edical Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last    IF FEMALE:	in the underlying cause given in Part I.  26. Place of Death (Che utpatient 3 DOA  Time of Injury M 1 Yes 2 No  arm, street, factory, office  28c. Injury at 28d. Injury at 28d. Injury at 28d. Injury at 28d. Injury Mork?  Injury M 1 Yes 2 No  arm, street, factory, office  28f. Loge, death occurred at the time, date and place, and dind/or investigation, in my opinion, death occurred at 29c. License number	23e. Did tobacco  24a. Was an autopsy performed?  29 Yes 22 No. 10 No. 1	23d. Date of delivery  Month Day Year  use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  ury occurred  and Number or Rural Route Number,  (e)  3) and manner as stated, d place, and due to the cause(s)  ate signed (Month, Day, Year)
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	1.	Decedent's Name (First, Middle	e, Last)	-							2. Date of De		-00	1	S. Time o	of Death-
hysician /Medical	_	David M.P. Rac	)								Month Augus	st 15	ž, 200	4	6:00	АМ
xaminer		. Facility Name (If not institution	n, give street i	and number)	)		4b. City, T	own, or	Location of	of Death		40	County of E	Death		
		Casey House					Ro	ckvi	ille				Montg	omer	Э	
neral ector		Social Security Number 367-44-9944	6. Sex 1 X M 2		ge (In yrs. 83	last birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	Min	8. Date of Bin (Month, Di Oct. 17	v. Year	9. 920 I	Birthpla Countr ndia	ice (State y) 1	or Foreign
		sual Residence of Decedent			100 Cit	y, Town or Lo	antion							10	d. Inside C	Disc Filming
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ect.	M	<u>laryland Montgo</u> le. Street and Number	omery		Silv	er Spr	ing 10f. Zip (	Codo				10a Ci	tizen of Wha	t Countr		
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ls 23	1	1215 Oakleaf I . Marital Status		LU as Decedent	Ever in II	S 13 1		901	isnanic Ori	ain? (Sne	ority Yes or No	-	14. Race - A	America	n Indian	
er, or rems 23e or 20e-1 st vardinar mast be notified by Funeral Director		1 ☐ Never Married 2 ▼ Married 3 ☐ Widowed 4 ☐ Divorced	ned 1 [	med Forces: ]Yes 2[X] Yes, Give	?	1	f Yes, specif		Specify:	n, Puerto	ecify Yes or No Rican, etc.)		Black, V Specify:	Vhite, et		Į
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imporant; in tem 2.1 is marked other their instities, or items 2.5s of 2.5s-1 show only injury or other treumatic event; if a Madical Everdher marker notified at once.  To Re Completed by Financial Director		(Specify only higher Elementary/Secondary (0-12)	st grade comp	oleted) ollege (1-4or	5+)	(Give	dent's Usual kind of work DO NOT use	done d retired	ation during mosi i)	t of workii	ng	160. K	(ind of Busine			
H C		'. Father's Name (First, Middle,	5+		<u>-</u>	Educ	ator		18 Mothe	r's Name	(First, Middle	Maider	Educa	1101	1	
To Be	Š	Mathi Prakasam	Lasty							_	ma Pada		,			
reuma	19	9a. Informant's Name/Relations Rosetta M. Ratl			or						Route Numb	-			Code)	
pther i	-	a. Method of Disposition			20b. F	Place of Dispo	sition (Name	e of			ate		ocation - City		n, State	
$Q_{\tilde{s}}$	1	1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		al from State	) [	cklawn	•	٠.		8/20	/2004	Rocl	kville	, MT	)	
ini e	21	1. Signature of Funeral Şervice		VI	1 41						es-Rina			-		
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		3a. Part1. Enter the disease, or shock, or heart failure. List nmediate Cause (Final	complication only one cau	s that cause se on each I	ine.					cardiac o	r respiratory a	rrest,		1	Approxima nterval Be Onset and	tween
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12.5	Č.	ause (Disease or injury	<b>`</b>											1		
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6	2		đ.													
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should be detached for use as	23	FEMALE: 3b. Was decedent pregnant		yes, outcome ⊒Live birth			Ectopic pre	onancy					23d. Date of			V.
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3	בי ב	art II. Other significant conditi	ons contributi	ng to death t	out not res	ulting in the u	nderlying car	use give	en in Part I.				use contribut			
ם ב	<u> </u>										1 🗆	Yes 2	<b>X</b> □No 3□	Probat	oly 4	Unknown
N 2	<u> </u>										24a. Was	osy		to comp	y findings pletion of	available cause of
Lag C	5										1 Yes	rmed? 2 🔀 No	deati	h? Yes 2	□ No	
q	25	5. Was case referred to medica examiner?								of Death	(Check only	one)				
을 F	100	1 ☐ Yes 2 ☐ No	Hospita	1 🔲 Inpati		ER/Outpatien		_	4 🗀 140	-	ne 5 🗆 Resi		6 <b>X</b> Other (5	Specify)	Hosp	ice
	5 27	7. Manner of Death 1 ⊈Natural 5 ☐ Pendir	ng	a. Date of Inju (Month, Da	ay Year)	28b. Time of Injury		c. Injury Work	c?		28d. Describe	how inju	ry occurred			
4	g	2 Accident investi 3 Suicide 6 Could	not be	Discount to	toran AA fe		М		Yes 2 □ I		306 1	044	and Advanced and a	. 016	O- 1: M	
ortification.		4 Homicide determ		building, e	tc. (Specil	ome, farm, str y)	eet, factory,	office		1	28f. Location ( City or To	street ar wn, State	na Number oi 9)	r Hurai F	Youte Nun	nber,
, le	)	9a. Certifier 1 X Certifyii (Check only 2 1 Medical	ng Physician Examiner: O	: To the best	of my kno	owledge, death	occurred a	t the tim	ne, date an	d place, a	and due to the	cause(s	) and manne	r as stat	ed.	e)
completely filled in by the funer		one)	ar	nd manner si	tated.					5000116						,
E CO	29	9b. Signature and title of certifie		1.1	1 -		29c.		number O 947	0			te signed ( $^{M}$			
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0		D. Name and address of person							TZ		300	200	0.5			
		Eugene P. Libr		32 Booin	JU Co	nnectio				ıngt	on, MD	208	70			
State		1. Date filed (Month, Day, Year)		32. Regist	rar's Signa	iture /		ark								

			1 - For State Registrar	State of Marylar	nd / Depa		Health an	•	-	04	28733
	Dhysisi	Á	1. Decedent's Name (First, Middle, Last)					2. Date of De	nath Day	Year	3. Time of Death
ĸ.	Physici /Medic		MELVIN HARRY RI	EDMILES				August		2004	11:30 P
	Examin	ier	4a. Fecility Name (If not institution, give s	street and number)		4b. City, Town, o	or Location of D	Death	4c. Coun	ty of Death	
W.			16600 Briardale F		In a thinth day.	Deerwo		Hrs Days of Die		tgomery	
p	Funeral Director		1 🔯	7. Age (In yrs.	. rasi birinday) Yrş.	Months Days		Vin. (Month, Da	ıy, Year)		ce (State or Foreig
			718.14.9621 Usual Residence of Decedent	09				May 8,	1915	⊥ wasni	ngton, D
	nylan ihow	_	10a. State 10b. County	10c. C	ity, Town or Lo	ocation				100	I. Inside City Limits
	Ba-f s	Director	Maryland Montgome	ry l	Deerwoo						1⊠Yes 2□No
	d within 72 hours after death with the Maryland liene. I then "neturel", or Items 23s or 28s-f show Itte Mudical Examil ter must be multied at		10e. Street and Number			10f. Zip Code			10g. Citizen of		y?
	s 23s	Funeral	16600 Briardale Ro	oad 12. Was Decedent Ever in U	10 12 1	20855	dianania Oriain	2 /Charity Van er Ne	U.S.	A . ice - Americar	Indian
	ter de	-un-	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?  1 Yes 2 No	J.S. 13.	If Yes, specify Cub	an, Mexican, P	? (Specify Yes or No Juerto Rican, etc.)	Bla	ack, White, etc	c.
036	urs af	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 <mark>1</mark> 2 No	Specify:		Speci	fy: Whit	e
2	72 ho	Completed	15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usual Occup	pation	working	16b. Kind of I	Business/Indu	stry
2	within lene. then	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. i	DO NOT use retire	id)				
Maryland 21215-0036			12th 17. Father's Name (First, Middle, Last)		Ass	sistant F		Name (First, Middle,			on Servi
anc	o d is p	Be		dmiles				ine Magde		me) Lammer	
$\frac{2}{5}$	should be ind Mental marked o	2	19a. Informant's Name/Relationship (Ty.		19h Mailir	na Address (Street		r Rural Route Numb			ade)
<u>8</u>	C 6 6 6		Joseph H. Redmiles					l, Deerwoo	-		
e,	item 27		20a. Method of Disposition	20b.		sition (Name of matory or other pla		Date	20c. Location		
E	Page Into		1 ☑ Burial 2 ☐ Cremation 3 ☐ R  1 ☐ Donation 5 ☐ Other (Specify)					3/26/2004	Brentwo	od, Ma	ryland
Baltimore,	permit. Pages to Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service Licens	Person	H]	Name and Address NES-RINA	ess of Facility LDI FUN Hampshi	NERAL HOME Lre Ave, S	INC.	Spring,	MD 2090
760,	Hysician // Medical Examiner pangle prigaritansi	cal Examiner	23a. Part1. Enter the disease, or complishock, or beartfailure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	quence of):					lr.	pproximate thereal Between onset and Death
.O. Box 68	death certifica e attending ph d for use as th	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	aldeath 3□	Ectopic pregnanc	у			ate of delivery onth Da	ay Year
S, D	es that igned b be deta	by Pt	Part II. Other significant conditions cor	tributing to death but not re-	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use cor	tribute to the	cause of death?
ğ	w require been sig should b							_ 10`	res 2 No	3 Probab	ly 4 ∐Unknown
Record	The lar ate has page 2	Completed						24a. Was autop perto 1 ☐ Yes			y findings available letion of cause of
Vital	Physicien; 1 this certifical ral director, p	Be	25. Was case referred to medical examiner?	lanaitai.				Death (Check only of			
0	Phys this	2	1 ☐ Yes 2∑ No  27. Manner of Death	ospital: 1 Inpatient 2 2	ER/Outpatien			ng Home 5 🖾 Resid			
		ion	1 X Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo		28d. Describe I	now injury occu	rrea	
Division	deat deat ctor: y the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str			28f. Location (5 City or Tox		ber or Rural F	loute Number,
	To the Hospitel or a within 24 hours after To the Funerel Dire completely filled in b	edicai C	29a. Certifier 1 Certifying Physical Control one) 1 Medical Examination	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or in	n occurred at the trivestigation, in my o	me, date and popinion, death of	lace, and due to the occurred at the time,	cause(s) and m date and place,	anner as state and due to th	ed. e cause(s)
•	To the vithing comp	Me	29b. Signature and title of certifier	like		29c. Licens	se number		29d. Date signe August		
	17		30. Name and address of person who co								
			Anushiravan Dadja					e, #201, R	lockvil]	Le, MD	20850
	Sta Registr		AUG 2 5 20	32. Registrar's Sign	ature 4	Spark	2				

			1 - For State Registrar	State of Maryl		ertment of Fertificate of		-	giene		287	31.
			Decedent's Name (First, Middle, La	ist)				2. Date of De	ath	1 -7	3. Time o	f Death
	Physici: /Medic		Marjorie Strea	ter Reid				August	22, 20	Year 04	8:45	A M
	Examin		4a. Fecility Name (If not institution, given	e street and number)		4b. City, Town, o	or Location of [	Death	4c. County	of Death		
			Doctors Communit			Lanham		Hrs. I a m / B:	Princ			
	Funeral Director			Sex 7. Age (In ) 1 ☐ M 2 【XF 75	rs. last birthday Yrs.	Months Days		Min. 8. Date of Bir (Month, Da 0ct • 2	8, 1928	Cour	place (State of try)  Ch Car	
		1	Usual Residence of Decedent					000. 2	1720	Doar	II Car	ULLIIA
	ryland		10a. State 10b. County		City, Town or L	ocation.				1	Od. Inside C	-
	Be-f s	cto	Maryland Prince (	George's L	anham							2 🗌 No
	with th	Dire	10e. Street and Number 4402 Braeside Co			10f. Zip Code			10g. Citizen of V		•	
	ns 23	era	11. Marital Status	12. Was Decedent Ever i	n U.S. 13	20706 Was Decedent of b	Hispanic Origin	n? (Specify Yes or No	United 14. Rac		es an Indian.	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show among your or other traumatic event, the Medical Examinar must be notified at another.	by Funeral Director	1 Never Married 21 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates:		If Yes, specify Cub  1 ☐ Yes 2 ☑ No	an, Mexican, F	Puèrto Rican, etc.)	Specify	ck, White, $\sim B1$	etc. .ack	
Q 2	72 ho	Completed	15. Decedent's E (Specify only highest gr		16a. Dec	edent's Usual Occup e kind of work done	pation	f working	16b. Kind of Bu	usiness/In	dustry	
7	ithin Je.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		D 1 1			
7	lled w tygier ther th		12 17. Father's Name (First, Middle, Lasi	)	Plana	agement A		Name (First, Middle,	Federal		ernme	nt.
and	d be f	o Be	Fred Streater	,				Clyburn	Walder Sumain	10)		
ary	shoul nd Me mari	丘	19a. Informant's Name/Relationship	Type, Print)	19b. <b>Ma</b> i	ling Address (Street	·	or Rural Route Number	er, City or Town,	State, Zip	Code)	
Š	alth a		Hubert Reid	(husband)	440	2 Braesid	e Court	, Lanham,	MD 207	106		
ore,	of He of He		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 [		b. Place of Disp cemetery, cri	oosition (Name of ematory or other pla	ce)	Date	20c. Location -	City or To	wn, State	
Ē	Pag ment lent: I		`4 ☐ Donation 5 ☐ Other (Speci	(y)	Chesape	ake Crema	tory 8	3/26/04	Beltsvi	.11e,	MD	
Baltimore,	permit Depart Import any n		21. Signature/of Funeral Service Lice	J. Olyhu		22. Name and Addre	ess of Facility Bia Ave	AcGuire Fu	neral Se ashingto	rvic	e ,C20	0012
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the cone cause on each line.	leath. Do not e	nter the mode of dyi	ng, such as ca	rdiac or respiratory a	rrest,		Approxima Interval Be Onset and	tween
	Pnysician		Immediate Cause (Final disease or condition	_a_ Respirato	ory Fail	lure					6 days	
В	/Medical Examiner		resulting in death)	Due to (or as a con								
		-	Sequentially list conditions,	b. Pneumonia						- + '	uays	5
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Renal Fai	llure					1	6 days	3
ó	exec en an	Еха	resulting in death) Last	Due to (or as a con	sequence of):							
68760,	ficate be executed physicien and is the burial-transit	edical		d. Carcinoma	of the	e Lung				10	ess 1	year
Вох	death certifics e attending ph id for use as t	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		□Ectopic pregnanc			23d. Dat	te of delive	ary	
o	0 0 2	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time		Other (specify)	y 		Mor	nth	Day	Year
s, P	res thai igned I be det	by P	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause giv	ven in Part I.		obacco use conti			
ord	w require been signal	ted			_			_ 101	res 2□No	3 🔼 Prob	ably 4 🗍	Unkriown
ecc	S S	Completed						24a. Was	osv r	prior to cor	psy findings apletion of c	available ause of
E E		Con						1 Yes		death?	2□ No	
Vits.	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott	or	Death (Check only o				
o	Phys ral di	.: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time	ALL SOLDON	4 🗆 Nursi	ng Home 5 Resident	dence 6 ⊡Othe now injury occurr		()	
on	th. : After e funer	atlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		r) Injury	Wo	rk? ∣Yes 2∐No					
Division of Vital Record	or Attendi after death. Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, s ecify)	treet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	er or Rura	l Route Num	iber,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 X Certifying P (Check only one)	hysicien: To the best of my miner: On the basis of exan and manner stated.	knowledge, dea nination and/or i	ath occurred at the ti nvestigation, in my o	me, date and popinion, death	place, and due to the occurred at the time,	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s	5)
	To the h within 24 To the F complete	Me	29b. Signature and title of certifier			29c. Licens	se number	.,	29d. Date signed	(Month,	Day, Year)	
)			> 5	70		D	3793	3 /	8/25		064	
	<b>)</b>		30. Name and address of person who		0 13 1		enter 5	Greenh	elt mo	2 .	770	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 26 2	32. Registrar's S	gnature	Spork						

RLENE RIC	HARD	For Unpend I	tem 23a, pt	Mazyland/Depa Ce	attiggentiqf- rtificate of	leealth ea Death	নুৰ Mental Hy	giene Rag. Not?	1 00705
		Decedent's Name (First, N	fiddle, Last)				2. Date of De		3: Time of Death
	sician edical	Darlene Ric	hards				AUG.	25, 2004	0742 A M
	miner	4a. Facility Name (If not instit	ution, give street and num	nber)	4b. City, Town,		Death	4c. County of	
		3501 PEAR 7			SILVER If Under 1 Yea	SPRING	Hrs   9 Date of Bir	MONTGO	
Fune		5. Social Security Number 217-70-8684	6. Sex 1 ☐ M 2 ☐ F	<ol> <li>Age (In yrs. last birthday)</li> <li>41 Yrs.</li> </ol>	Months Days		Min. 8. Date of Bin (Month, Da	y, <sub>Year)</sub> 8, 1963	Birthplace (State or Foreign Country) Washington, DC
Direc	or	Usual Residence of Deceder	it	41					
aryland		10a. State 10b. Co	unty	10c. City, Town or Le					10d. Inside City Limits
the Mar	Director	Maryland Me	ontgomery	Silver	Spring				1 ☐ Yes 2X No
ith th	Dire	10e. Street and Number			10f. Zip Code	_		10g. Citizen of Wha	at Country?
ath w	iai	3501 Pear Tr		edent Ever in U.S. 13.	2090		n2 (Specific Vac or No	USA	American Indian,
Ind 21215-0036  be filed within 72 hours after death with the Maryland tial hygiene. Indicate than "natural", or Items 23a or 28a-f show	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐  3 ☐ Widowed 4 ☐ Divo	Armed For 1 ☐ Yes If Yes, Giv	2 <b>∑</b> No ∕e	Was Decedent Of If Yes, specify Cu 1 ☐ Yes 2 1 No		n? (Specify Yes or No Puerto Rican, etc.)	Black, Specify:	White, etc. White
5-003	ted	15. Dec	edent's Education ighest grade completed)	16a. Dece	dent's Usual Occi	upation e during most o	of working	16b. Kind of Busin	ness/Industry
21215 ad within 7 /giene.	Completed	Elementary/Secondary (0-		life.	DO NOT use retir	·ed)			,
Maryland 2121 12 should be filed within h and Mental Hygiene. 7 is marked other than "	្ង	17 Cathada Nama (Cimt Mi	2	Sec	retary	18 Mother's	s Name (First, Middle	Cleric	
d as b	Be	17. Father's Name (First, Mic	ene Richards				11a Theo	, Maiden Sumame,	
ryls houtd d Mer	ဥ	19a, Informant's Name/Rela			na Address (Stree		or Rural Route Numb	er, City or Town, St	ate, Zip Code)
Maryland to 2 should be file th and Mental Hy to 1s marked oth	To	Stella Theo			•		orest Rd.,		
re, s 1 an Heal		20a. Method of Disposition		20h. Place of Disp	osition (Name of	lace) A	ugust 28,	20c. Location - Ci	ty or Town, State
Page:	0	1 ⊈Burial 2 ☐ Crema 1 4 ☐ Donation 5 ☐ Oth	tion 3 Removal from er (Specify)		matory or other p. Heaven etery		2004	Silver Sp	oring, Maryland
Baltimore, Mipone, Manuel. Pages 1 and 2 Department of Health a Important: If them 27 is	once.	21. Signature of Funeral Se	vice Librage				ns Funeral		c. cing, MD 20901
Physic	an	shock, or heart failure.	List only one cause on e	aused the death. Do not en	ter the mode of d	ying, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between
/Medi Exami	cal	disease or condition resulting in death)	a	(or as a consequence of):					
Exam		Sequentially list conditions,	b. Due to	(or as a consequence of):					
pe	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺ 550.0	(or <b>25 2</b> 557559 <b>3</b> 57155 51).					
8760, ate be executed hysician and	Examiner	that initiated events resulting in death) Last	C	(or as a consequence of):					
760 e be			d						
X 687 certificate	Aedic	IF FEMALE:						11	
. Bc death	Physician/Med	23b. Was decedent pregnal in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live b	nant at time of death 5	□Ectopic pregnar □ Cther <i>(specify)</i>			23d. Date of Month	•
		Part II. Other significant co	nditions contributing to d	leath but not resulting in the	underlying cause	given in Part I.	- 1		ute to the cause of death?  Probably 4 [Unknown]
e law	Completed by						24a. Was auto perfo	ormed? dea	ore autopsy findings available or to completion of cause of white the completion of cause of the
Vital Fician: The	orrector.	25. Was case referred to m examiner?					of Death (Check only		
of Vital Physician: this certific	- 15	1 XYes 2 ☐ No		Inpatient 2 ER/Cutpatie			sing Home 5 Res	idence 6 10 Other	
Jing P	the tuneral		oriumg	of Injury 28b. Time Injury Injury	W	lury at /ork? □Yes 2□N		now injury occurred	
ISÍO Ntendii death. ctor: A	ine i	3 ☐ Suicide 6 ☐ C	ould not be 28e Place	e of Injury - At home, farm, s			28f. Location (	Street and Number	or Rural Route Number,
Div after Direc	ed in by the tunera	4 - Homicide	letermined 200. Flace build	e of Injury - At home, farm, s ling, etc. (Specify)	,		City or To	wn, State)	
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	oletely filler	29a. Certifier 1 ☐ Ce (Check only 2 ☑ Me	dical Examinar: On the b	e best of my knowledge, dea pasis of examination and/or inner stated.	th occurred at the nvestigation, in m	time, date and y opinion, death	place, and due to the n occurred at the time,	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)
To the within To the	dmoo	29b. Signature and title of c	ertifier Mar	4 Alga	29c. Lice	onse number D.C.M.E		29d. Date signed (	Month, Day, Year) 6, 2004
- (		30. Name and address of p	erson who completed cau	ise of death (Item 23a) (Type 111 Per	n Street	t, Balt:	imore, Mar	yland 212	01
Re	State gistrar	31. Date filed (Month, Day, AUG 2	7 2004 32.	Registrar's Signature	Spore	2			

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

								imoato o	f Death		Reg. No.	14 2	2 1 4 5
	Physic	ian	1. Decedent's Name	a (First, Middle	, Last)					2. Dete of De Month		Yeer 3.	Time of Death
	Physic /Medi		_ JEAN C.							AUGU			10:00 AM
	Exami		4e Fecility Neme (fi	f not institution	n, give street end num	iber)			4b. City, Town, o	r Location of Deat		y of Deeth	
					R NURSING	HOME _			SILVER S		MONTO	GOMERY	
	Funeral		5. Social Security N		6. Sex 7		s. last birthday)	If Under 1 Yea Months Dey		S. 8. Date of Bi	rth Vagri	9. Birthplace	(State or Foreign
	Director		459-52-64	–	1 □ M 2 □xF	90	Yrs.	Monus,	S Hours	OCT. 1	3, 1913	Arkans	as
	D .		Usuel Residence of	Decedent									
	within 72 hours after death with the Marylend ena. than "natural", or fema 23a or 28a-f show he Medical Evantine must be notified at		10a. Stete	10b. County		10c. C	City, Town or Lo	cation					nside City Limits
	Ma-f-	cto	Maryland	Montgo	omery	Whe	eaton					1	Yes 2□No
	or 28	Director	10e. Street end Nun	nber	-			10f. Zip Code	)		10g. Citizen of	Whet Country?	
	23a c	ain	2008 811	- C-211	T			209	906		US	A	
	Jeath Jeath	Be Completed by Funeral	2808 Blu 11. Marital Status	e Spru	12. Was Deced	dent Ever in I	U.S. 13. V			Specify Yes or N		ce - American Ir	ndian.
10	har d	F	1 Never Marrie	ed 2∏ Marri	Armed Fore	ces?			f Hispanic Origin? ( uban, Mexican, Pue	rto Rican, etc.)	Bla	ick, White, etc.	roman i,
336	rs af	ò	3 Widowed		ied 1 ☐ Yes 2 If Yes, Give Year or Da	X		1□Yes 2【 N	o Specify:		Specia	<sup>∱y:</sup> White	
Ö	hour	8		15. Decedent'		162.	153 Decer	"" Henel Occ				WIIILE	
21215-0036	- na	et	(Speci	ify only highest	t grade completed)		(Give	kind of work don	upation se during most of we red)	orking	16b. Nina or a	Business/Industr	у
12	withii ana. Ithan	E	Elementary/Secon	ndary (0-12)	College (1-	4or 5+)			Provider		TIOMAG		
7	led v tygie her t	ဒီ					110	Mecare 1			Homec		
Inc	d dail H	Be	17. Father's Neme (	First, Middle, L	_ast)					ame (First, Middle		me)	
<u>yla</u>	Man Man Mrke	2	Jethro H						Katnie	en MacIn	tosh		
Maryland	s me		19a. Informant's Na	me/Relationsh	nip (Type, Print)		19b. Mailin	ng Address (Stree	et and Number or F	lural Route Numb	er, City or Town	, State, Zip Cod	Θ)
Σ	alth	J	L.Ann Ha	tch-Da	nghter		2808	Blue Spr	uce Ln.	Wheaton,	MD 209	06	
J.	f He f He oth	- 1	20a. Method of Disp	position		20b.	Place of Dispo	sition (Name of natory or other pi	()	Date		- City or Town, S	State
20	age into t: if	6			3 □Removal from S				Cemetery	8/23/04	Cilver	Saring	MD
Baltimore,	그 된 존 등	-	4 ☐ Donation						ress of Facility 1:			_	
Ba	permit Deper Impor Impor any in		21. Signature of Far	neral Service L	icensee								
-	<u>~</u> = =		1900	Wu U	1).		+ -	SOO WEM	Hampshir	e Ave. 5	ilver o	pring,	MD 20904
			23a. Pert1. Enter th	e disease, or o	complications that can	used the dea	ath. Do not ente	er the mode of dy	ving, such as cardia	ac or respiratory a	rrest,	App	roximate
	Physician		SHOCK, OF THE	t failure. Loc	only one cause on oc	ch line.						Inte	rval Between et and Death
	/Medical		Immediate Course (										· · · · ·
	/Itimes.	- 1	Immediate Cause (F	Tinal			**						
	Examiner		disease or condition resulting in death)	Final 1	a			eart Fai	.lure			1	
	Examiner		disease or condition	Final า	u	Due to (	(or as a conseq	uence of):	.lure		-	1	-
		nlner	disease or condition resulting in death)	n	u	Due to (		uence of):	.lure			1	
		nlner	disease or condition resulting in death)	n	u	Due to ( Atrial	(or as a conseq	uence of): llation	.lure				
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P.O. Box 68760,		Physician/Medical Examiner	disease or condition resulting in death)  Sequentially list con if eny, leading to imicause. Enter Under Cause (Disease or it that initieted events resulting in death) L	nditions, mediate rlying injury .ast	b	Due to (c Atrial Due to (c	(or as a consequence of the cons	uence of):  11ation uence of):  uence of):				intribute to the	
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ords, P.O. Box 68760,		by Physician/Medical Examiner	disease or condition resulting in death)  Sequentially list con if eny, leading to immocause. Enter Under Cause (Disease or it that initieted events resulting in death) L  Part II. Other significations.	nditions, mediate rlying injury .ast	b	Due to (c Atrial Due to (c	(or as a consequence of the cons	uence of):  11ation uence of):  uence of):		1 ☐ 24a. Wes	Yes 2□ No an autopsy	3 Probabiy	4 Unknown
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** рм 4:22 /Medical Hector Evelio Rosales August 2004 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Silver Spring Holy Cross Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Min. 1[XM 2□ F Yrs. Director None 0 August 22, 2004 Maryland 52 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Mcdical Examinar must be notified at 10d. Inside City Limits 1 Tyes 2 TaNo Directo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10510 Insley Street by Funeral 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Fages 1 and 2 should be filed within 72 hours after Copartment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or les any loiury or other traumatic event, the Medical Examines once. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: Honduran Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hector Rosales Gladis Alvarado 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladis Alvarado/ Mother 10510 Insley Street, Silver Spring, MD 20902 20b. Place of Disposition (Name of 20a. Method of Disposition August 25, 20c. Location - City or Town, State netery, crematory or other pi Metropolitan other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Crematory Alexandria, Virginia 21. Signatur / Fuderal Service Lizes 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, Md 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Extreme Prematurity /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, lary, leading to innectate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine requires that the death certificate be executed attending physicien and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown t d ber Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š should be o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2⊠ No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဥ 1x Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 K Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Americal examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and little of certified 29c. License number 29d. Date signed (Month, Day, Year) August 23, 2004 D20524 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd., Silver Spring, MD 20910 Steven P. Wyner. M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Oay, Year)

**AUG 26** 

2004

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			1 - For State Registrar	State of Mis	-		tificate of	ieaith and iv Death	, ,	eg. No. O O O	
			Decedent's Name (First, Middle, Last	st)		-			2. Date of Deat	n 6001	3. Time of Death
	Physici /Medic		Frank Austin Rho	odes					August	27, 2004	3:30 p M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of Death		4c. County of De	ath
			10 Meadowside				Indian I				arles
	Funeral Director		5. Social Security Number 6. Security Number 1217–36–9398	ex 7.Age ¶TM 2□F	e (In yrs. last birt 62	hday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, ctober 2	<sup>Year)</sup> 1941	ithplace (State or Foreign Country) Maryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Loc	ation				10d. Inside City Limits
	Maryl.	tor	Maryland Charles	9			Head				1  Yes 2 No
	r 28a	Director	10e. Street and Number	<u>.                                    </u>	1110.	Lan	10f. Zip Code		10	Og. Citizen of What C	Country?
	th with		10 Meadowside	Court			20640	)		U.S.A.	
	within 72 hours after death with the Maryland ene. then "naturel", or Iteme 23e or 28e-f show to M. Jical Exs. if or r. ust Le ricillist.	by Funerai	11. Marital Status	12. Was Decedent 8 Armed Forces? 1 XYes 2 □ N		13. W	/as Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
Maryland 21215-0036	ours aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 <del>反</del> Divorced	If Yes, Give Year or Dates:	10	1	☐Yes 2 <mark></mark> No	Specify:		Specify: W	hite
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a.	(Give k	ent's Usual Occup	durina most of worki	ng	16b. Kind of Busines	s/Industry
7	within lene.	omp	Elementary/Secondary (0-12)	College (1-4or 5		_	onoruse retired sive Test	" t Operatoi	<u>.</u>	U.S. Gove	cnment
פַ	il Hygie other	Be C	17. Father's Name (First, Middle, Last)		1			18. Mother's Name			
<u>lar</u>	2 should be and Mental Is marked o	To E	Lomax B. Rhode	s				Helen S	prague R	hodes	
Jan	and la ma		19a. Informant's Name/Relationship (7							City or Town, State,	
	1 and 1 Health em 27		Patricia R. Harde 20a. Method of Disposition	er / Niece			eadOWS106 ition (Name of atory or other place	e Court; I	ate	Oc Location - City o	20640
altimore,	Pages nent of ant: If it ary or o		1 □XBurial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify		1			<sup>38)</sup> Septer Cemetery	nber 2,	2004 heltenham	, Maryland
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Iteme 23a or 28a-f show any injury or other treumatic event, In a Medical Exp. If ref river the incilling at once.		21. Signature of Funeral Service Licen	500	MOOGER			ss of Facility Wil	lliams F	uneral Hor	me, P.A.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	M00668 the death. Do n				<u> </u>		aryland 20640
	Pnysician		Immediate Cause (Final disease or condition	one cause on each lin	e.	17	-c Carac	em i na	A C	il oni	Interval Between Onset and Death
	/Medical		resulting in death)	a. Due to (or as a	consequence of		0 0 1.0		( )		~ years
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Records,	w require been sign	etec				·					
Ř	The law cate has page 2 t	Completed							24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
Vital		BeC	25. Was case referred to medical					26. Place of Death	1 ☐ Yes 20 (Check only one		s 2□ No
ot	Physicien: r this certific ral director,	P	1 183 2 110	Hospital: 1 ☐ Inpatier		patient	3□ DOA Othe	er: 4 🗆 Nursing Hon	ne 5 Resider	nce 6 Other (Spe	ecify)
O UC	fte an	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Ti	me of jury	28c. Injury Work	at 2	8d. Describe how		
Division	Attending or death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be		ry - At home, far	m, stre			8f. Location (Stre	eet and Number or R	ural Route Number,
2	F SF C	Certification:	4 Homicide	28e. Place of Inju building, etc	. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	State)	
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best o liner: On the basis of and manner stat	examination and	death /or inve	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	nd due to the car od at the time, da	use(s) and manner at te and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	$\wedge$	N		29c License	number	29	d. Date signed (Mont	th, Day, Year)
			2/2ml	Ind	1 00		DD	50%	4	8/3	0/0/
M	Ploof		30. Name and address of person who o	completed cause of de	ath (Item 23a)	ype, P	WAL	DIRE	mil	206	0'3
	Sta		31. Date filed (Month, Day, Year)		r's Signature		( d .				
	Registra	ar	AUC 3 O	2004	100 0 660	-	TATTO CALL				

		1 - State Unpend Item Registrar  1. Decedent's Name (First, Middle, La.				Doui	2. Date of Deat		2873
ysicia	ın	Jack Layman Rec	•					31, 2004 Year	3. Time of Death
/ledica amine		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death	August	4c. County of Death	1130 A
		12021 N Scottish	Court		Hagers	town		Washingt	on
eral ctor		217-00-0300	ex	s. last birthday Yrs.	Months Days		8. Date of Birth (Month, Day, Septembe	Year) 1962 9. Birthp	place (State or Foreigntry) y Land
		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or L	ocation				0d. Inside City Limit
	ctor	Maryland Washing	gton		Hage	rstown			1 □ Yes 2X N
-	Dire	10e. Street and Number	_		10f. Zip Code		10	0g. Citizen of What Cour	ntry?
	a.	12021 N. Scottish		110	10.	21740		U.S.A.	
1	by Funerai Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Fif Yes, specify Cub	Hispanic Origin? (Specan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	dent's Usual Occup	pation during most of worki	ng	16b. Kind of Business/Ind	dustry
	шc	Elementary/Secondary (0-12)	College (1-4or 5+)	life.				-	
	Be	17. Father's Name (First, Middle, Last)			Roofer	18. Mother's Name	(First, Middle, M	Roofing Co.	
	10 B	Jack Layman Re	ed, Sr.			Linda S	hubert		
	43	19a. Informant's Name/Relationship (7	Type, Print)	14				City or Town, State, Zip	
		Brenda L. Reed (W						own,Maryland	
		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □			osition (Name of matory or other pla			20c. Location - City or To	
XIIXE.	4	<ul><li>4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funeral Service Licen</li></ul>			n Cemeter		7,2004	Hagerstown,	Maryland
		Lacara Service Licent	The second	211111 4	2. Name and Addre	oss of Facility Usb	orne Fur	neral Home, Nagerstown,Ma	A. 21795
	1	28a Part - Enter the disease, or comp	olications that caused the dea	ath. Do not en	er the mode of dyir	ng, such as cardiac o	r respiratory arre	st.	Approximate
		Immediate Cause (Final	one cause on each line.  Diabetic k						Interval Between Onset and Death
1		disease or condition resulting in death)	Due to (or as a conse		10212				
ı	.	Sequentially list conditions	b						
١	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Clisters of the property that initiated events	Due to (or as a conse	quence of):					
	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	guence of):					
				400.000 01,1					
:	edic		d						
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)	У		23d. Date of deliver Month	ry Day Year
	by Ph	Part II. Other significant conditions co	ontributing to death but not re	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to the	e cause of death?
1	Ted Ed						1 🗆 Yes	s 2 □No 3 □ Proba	abiy 4 DUnknown
-	Completed						24a. Was an autopsy	prior to com	sy findings available
	5						perform 1 1 es 2	ed? deathe	2□ No
10	g	25. Was case referred to medical examiner?	Hospital:		Cth	26. Place of Death		The state of the s	~
	0	1 XYes 2 No 27. Manner of Death	1 Unpatient 2L	ER/Outpatier 28b. Time of	t 3 DOA	4 Nursing Hon	ne 5 Residen	ce 6 COther (Specify,	At scene
	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wor	yat k? Yes 2 □ No	od. Describe now	valiary occurred	
1017	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str ify)	eet, factory, office	2	8f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☑ Medical Exem	vsician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, deatl ation and/or in	occurred at the ting estigation, in my o	me, date and place, a pinion, death occurre	nd due to the cau d at the time, dat	use(s) and manner as sta e and place, and due to	ited. the cause(s)
	M	29b. Signature and title of certifier			29c. Licens	e number	290	d. Date signed (Month, D	Pay, Year)
		1 Oxpher	M		0.0	C.M.E.	Se	ptember 01,	2004
		30. Name and address of person who c	completed cause of death (Ite		ŕ			Maryland 21	
		I DITING IO	v = ///// < * //	1.1	- LACTELY C.+	T-7	L 2		~~~

			For Stete Registrar	State of Ma	aryland / Depa	artment of rtificate of		and Me		iene	01.	007	1.0
	Physici	an	Decedent's Name (First, Middle, Last)						<ol><li>Date of Death Month</li></ol>	Day	Year	3. Time of	Death.
	/Medic	al		iderman		11. C. T		(5 "	08	24	04	5:45	A
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town,		of Death			ty of Death		
	Funeral		4925 Battery Lane 5. Social Security Number 6. Sex		e (In yrs. last birthday)	Bethe	r   If Under		8. Date of Birth	Montg	9. Birthr	place (State o	or Foreign
и	Director		578 <b>-</b> 32 <b>-</b> 7351	M 2□F	99 Yrs.	Months Days	s Hours	Min.	10 20	<sup>Year)</sup> 1904	New	Haven,	CT.
	put &		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation						I 0d. Inside Ci	ity Limita
	Maryli f sho	٥		***	Wheaton							1 ☐ Yes	-
	the 288-	Director	MD MOntgomer  10e. Street and Number	У	wileaton	10f. Zip Code			10	g. Citizen of	What Cour		
	h with		2602 Weisman Road			2090	2			US.	A		
	ams a	Funeral	11. Marital Status	2. Was Decedent 6 Armed Forces?	Ever in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Original	gin? (Spec	cify Yes or No-		ice - Americ		
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔀 N If Yes, Give	10	1□Yes 2☑No			,		% Whi₁		
21215-0036	72 hours after death with the Maryland natural', or itams 23a or 28e-f show iteal Evant without be notified at		3 ★Widowed 4 Divorced	Year or Dates:	16a Dece	dent's Usual Occu	ination			6b. Kind of 8			
215	within 72 ene. then "na he Wedic	Completed	(Specify only highest grade		(Give	kind of work done DO NOT use retir	e during most ed)	t of workin	g	OD. KING OF	Juan 1633/11)	dustry	
212	ed withir giene. ar then	Com	Liellielitary/Secondary (0-12)	4 yrs	, I	ngineer			U	. S. Go	vern	nent	
nd	be filed within 72 hours after death with the Marylan hat Hygiene. ad other then "natural", or flams 23a or 28e-f show avent, the Medical Examiner meat be pulified at	Be	17. Father's Name (First, Middle, Last)	-					(First, Middle, M	laiden Suma	me)		
yla	2 should be to and Mental I is marked of reumatic ave	P	Harris Sneiderma		10): 14 37				Brandt				
Maryland	ges 1 and 2 should it of Health and Men it itam 27 Is marks or other traumatic		19a. Informant's Name/Relationship (Type Charles Sneiderman			ng Address <i>(Stree</i> Battery							
ē,	of Health itam 27		20a. Method of Disposition	7 5011	20b. Place of Dispo	sition (Name of	1			Oc. Location			
Baltimore,	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State		natory or other pl		3-27-0	)/ı	1exand	Iria	<b>V7</b> A	
alti	permit. Page Department of Important: If any injury or once.	İ	21. Signature of Funeral Service License	ө	Metropo	2. Name and Add	ress of Facilit	y Mars	shall's	Funera	il II. il Hon	ne	
m	D B E B		2 p Marshal	20		4217 9th							
			23a. Pan 1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused e cause on each lin	the death. Do not ent ne.	er the mode of dy	ring, such as	cardiac or	respiratory arre	st,		Approximate Interval Bets	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	Renal	Failure							Onset and (	Jeath
	/Medical Examiner		resulting in south	Due to (or as	a consequence of):								
٤	*	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):		-						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events										
o,	an an arial-tr		resulting in death) Last	Due to (or as	a consequence of):								
8760,	death certificate be executed e attending physician and of for use as the burial-transit	an/Medical	d								-		
9	entific ding p	/Med	IF FEMALE:	c. If yes, outcome	of programmy								
Вох	eath certific attending p I for use as I	cian	in the past 12 months?		2 Fetal death 3	Ectopic pregnant Other (specify)	су				ate of delive onth		rear .
0	the y th iche	Physici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		_ caror (opecy)							
ď.	requires that een signed b nould be deta	by P	Part II. Other significant conditions con		ut not resulting in the u	nderlying cause g	iven in Part I.		23e. Did toba	acco use con	tribute to th	ne cause of d	eath?
ırd	w require been sig should b		Alzheimer's Dise	ase					1 🗆 Yes	s 2x No	3 ☐ Prob	ably 4 🗆	inknown
ecc	aw as b	ompleted							24a. Was an	.	Were auto	psy findings a	available ause of
= E		Соп							perform	ed? □ No	death?	2 No	
Vital Records,	Physician: This certificate al director, p	Be	25. Was case referred to medical examiner?	ospital:		0		of Death	(Check only one	)			
o	Phys rthis ral dii	. To	1 Yes 2 No	1 LI Inpatie	nt 2 ☐ ER/Outpatier  y 28b. Time o	IL 3 DOA			e 5 Resider			ASSIS Livin	
on	Attanding I r death. actor: After by the funer	tlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year) Injury	Wo	ork? ∐Yes 2∐1					.=11-7. 15-100 <del>0</del>	
Division		ertification;	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farm, str	eet, factory, office	•	28	8f. Location (Stre City or Town,	eet and Num	ber or Rura	I Route Num	ber,
	tal or A	Cert	1.00000	building, ex	. (Specify)				Only of Yount,				
	To the Hospital or within 24 hours afte To Iha Funaral Dir completely filled in	edical	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Exemin	er: On the best of and manner sta	of my knowledge, death examination and/or in ited.	h occurred at the t vestigation, in my	time, date and opinion, deat	d place, ar th occurred	nd due to the car d at the time, da	use(s) and m te and place,	anner as si and due to	ated. the cause(s	)
	To the within 2 To Iha complet	Σ	29b. Signature and title of certifier			29c. Licer	nse number		29	d. Date signe	ed (Month,	Day, Year)	
,			'ale	1	0	D 26	259		8	3-25-0	4		_
1	L (1)		30. Name and address of person who cor		eath (Item 23a) (Type, Wiconsin		2 D.+L	00000	мъ	0081/			
Y	. Sta	te	Ava A. Kavfman, M. 31. Date filed (Month, Day, Year)		W1CONS1N ar's Signature	AVE. #10	Deri	icoua	9 FI.D. 2	-0014			
	Registr		AUG 2 7 2004	Kedin	1 hours	W							

			For	State of Maryland /	Department of Health and M	Mental Hygie	ne
			1 - Stata Registrar		Certificate of Death	Rag.	
П	Physicia	an	Decedent's Name (First, Middle, La				Day Year
	/Medic	al	Charles Conrad  4a. Fecility Name (If not institution, give	Settle	4b. City, Town, or Location of Death	August	30 2004 0447 PM 4c. County of Death
	Examin	er					
	Funeral			Sex 7. Age (In yrs. last b	irthday) If Under 1 Year   If Under 24 Hrs.		Washington  9. Birthplace (State or Foreign
	Director		213-40-4580	1 X M 2□ F 64	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 26, 19	40 Maryland
	pur		Usual Residence of Decedent  10a, State 10b, County	10c City To	wn or Location		Tod India Challen
	Aaryla r sho	ō					10d, Inside City Limits 1 □Yes XXNo
	28e-1	Director	Maryland Wash  10e. Street and Number	ington	Williamsport 101. Zip Code	100	Citizen of What Country?
	3e or			0.11	21795	109.	USA
	death ms 2	Funeral	8674 Downsville 11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian,
9	after or Ite	Ful	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White, etc.
21215-0036	72 hours after death with the Maryland natural', or Items 23e or 28e-f show Jicel Evani net must be troffled ut	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			Specify: White
15	"nate	Completed	15. Decedent's E (Specify only highest gr		<ul> <li>Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)</li> </ul>	king 16b	. Kind of Business/Industry
12	withi ene. then	dwo	Elementary/Secondary (0·12)	College (1-4or 5+)	Assembler		must. Manuel at a
	filed Hygi other ent,	a	17. Father's Name (First, Middle, Last	)		e (First, Middle, Maid	ruck Manufacturer
lan	lid be fental rked ic ev	To B	Thomas Richard	Settle	Alvion	a_Jennet	to Emuch
Maryland	shou s ma	_	19a. Informant's Name/Relationship (		b. Mailing Address (Street and Number or Rui		
	and 2 salth in 27 l		Rebecca A. Settle	- Wife 8	674 Downsville Pike W	/illiamspo	rt,Maryland 21795
ore	of He		20a. Method of Disposition 1) 8 urial 2 Cremation 3		of Disposition (Name of ery, crematory or other place)	Date 20c.	. Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show eny injury or other treumatic event, the Medical Exantia character notities at 2000.		`4 ☐Donation 3 ☐ Other (Speci	Cedar	Lawn Mem. Park Sept.	2,2004 Has	gerstown.Maryland
3al	permit Depar Impor eny in		21. Sign were of Funeral Service Inc.	ise .	Osborne Aduneración Hom	e, P.A.	21795
	40200		23a, Part1 Enter the disease, or com	Directions that caused the death. Do	425 S. Conococheagu	e St. Wil	
	way read		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Y With	pu myeur	nc	extreme
п	Examiner		- 1	Due to (or as a consequence	(of):		
10		ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	of):		
	cuted id ransit	Examln	cause. Enter Underlying Cause (Disease or injury that initiated events	C			
o,	e exerian ar	Ex	resulting in death) Last	Due to (or as a consequence	of):		
8760,	cate be executed physician and the burial-transit	dical		_ d			
9		Mec.	IF FEMALE:	00-14			
Вох	death certifi e attending d for use as	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death			23d. Date of delivery  Month Day Year
o.		Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)		
<u>α</u>	law requires that the death certif as been signed by the attending 2 should be detached for use a	by Ph	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
rds	quires n sign					1 ☐ Yes	2 ☐NO 3 ☐ Probably 4 ☐Unknown
Records,	s been si	olete				24a. Was an	24b. Were autopsy findings available
Ä	0 - 0	Completed				autopsy performed′ 1 ☐ Yes 2 ☐	
Vital	ysicien: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)	10103 2010
of V	g :: 38	2	1 ☐ Yes 2 ☐ NO	Hospital: 1 Inpatient 2 ☐ ER/O	utpatient 3□ DOA Other: 4□ Nursing Ho	ome 5 🗆 Residence	6 □Other (Specify)
n	ding Ph h. After th funeral	on:	27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of Injury 28b. (Month, Day Year)	Injury Work?	28d. Describe how in	njury occurred
sio	Attending r death. sctor: After by the fune	cat	2 Accident investigatio 3 Suicide 6 Could not b	A	M 1 Yes 2 No		
Division	or At after of Direct in by	Certification;	4 Homicide determined		arm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Aural Route Number, ate)
	ours sours serel filled		29a. Certifier 1 Certifying Pr	vsician: To the best of my knowledge	e, death occurred at the time, date and place,	and due to the cause	Ve) and margar on stated
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	(Check only 3 Medical Examone)	niner: On the basis of examination are and manner stated.	nd/or investigation, in my opinion, death occurr	red at the time, date a	and place, and due to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	1 /	29c. License number	29d. [	Date signed (Month, Day, Year)
	,		* freder	u 1 X	1 NN 173623	A	PUTIC US teur
	,8		30. Name and audress of person who	completed cause of death (Item 23a)	(Type, Print)	IN	1
1			V-1101511	+ LASCIIII	no IIII o miel	will be	ha pro Kol
-	**			1 1 1 2 3 - 1	17 11110		41 04 0
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	A. V.	1. Lorge of	town hall 2174
- PI-	Sta Registra MH 17 Rev 1/20	ar		32. Registrar's Signature	Spele	Hogers	town hr 1 2174.

ORIGINAL

			For State Registrar	State of	Marylan		artment rtificate			and M		giene Reg. No	1000	21	37	42
39	Physicia	an	1. Decedent's Name (First, Middle, La	st)							2. Date of De Month	ath Da	y Yea		Time of E	Death
	/Medic			Marie							Septemb	- T	1 200		040	A M
17	Examin	er	4a. Facility Name (If not institution, giv	e street and nun	nber)		4b. City, To		Location o	of Death			County of D	eath		
			Union Hospital  5. Social Security Number   6. S	AY	7. Age (In yrs.	last hirthday)	If Under 1	ton	If Under:	24 Hrs.	8 Date of Bir		Cecil	Rirthnlace /	State or	Foreign
	Funeral Director			_M 2ÅF	62	Yrs.		Days	Hours	Min.	8. Date of Bin (Month, Da June 21,	y, Year) 1942	) N	Sirthplace ( Country) [ary] a		i di eigit
	ס		Usual Residence of Decedent													
	arylan show	_	10a. State 10b. County			y, Town or Lo	cation								side City	
	Ba-f	ecto	Maryland Cecil		El	kton	1					4			Yes :	
	with the	=	10e. Street and Number				10f. Zip C						izen of What			
	eath	eral	328 West Main St	···	dent Ever in U.	S. 13 '		921	snanic Orig	nin? (Spe	cify Yes or No		nited 14. Race - A			
	fter d r item niner	Funeral Director	1 ☐ Never Married 2 Married	Armed For 1 ☐ Yes	rces? 2[XNo					, Puerto I	cify Yes or No Rican, etc.)		Black, W			
ž O	ral', o	ò	3 Widowed 4 Divorced	If Yes, Giv Year or Da	e ates:		1 ☐ Yes 2	IXI No	Specify:				Specify:	White		
2-C	within 72 hours after death with the Maryland ene. Than "natural" or items 23e or 28a-f show he Madical Examiner must be mailfed at	Completed by	15. Decedent's En (Specify only highest gra	ducation ide completed)		16a. Dece	dent's Usual kind of work DO NOT use	Occupa	tion uring most	t of workii	ng	16b. K	ind of Busine	ss/Industry		
121	within	mp	Elementary/Secondary (0-12)	College (1	-4or 5+)							ļ.,				
2	filed v Hygie other t		12   17. Father's Name (First, Middle, Last,			Home	emaker		18. Mothe	r's Name	(First, Middle,		Her Ow Sumame)	n Hom	e	
a	d be a	To Be	Arthur Melvin Re								essie S		-			
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan a nard Memtal Hygiene a nard Memtal Hygiene is marked other than "natural", or flems 23e or 28a-f show is marked other than "natural" or flems 23e or 28a-f show raumatic event, the Medical Examiner must be multilled at	F	19a. Informant's Name/Relationship (			19b. Mailir	ng Address (	Street a			Route Number			a, <i>Zip C</i> ode	)	
Š	alth a		James N. Sample	Jr./Hu	sband	328	West M	lain	Stre	et,	Elkton	Ma	ryland	2192	1	
č.	ss 1 a of He item		20a. Method of Disposition	No	20b. P	lace of Dispo	sition (Name	e of ner place	)   5	dept.e	mber	20c. Lo	cation - City Sapeak	or Town, S	tate	
Ĕ	Pages nent of ent: If it ury or o		1 🕅 Burial 2 □ Cremation 3 □  1 4 □ Donation 5 □ Other (Specit		State [	thel C			1	, 20			/land	e cir	у,	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic ev 2009.		21. Signature of Funeral Service Licer	isee			Name and				rals, E	P. A.				
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	To the Hospital or Attending Physicien: The lay within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the Luneral director, page 2	edical (	29a Certifier 1 Certifying Pt (Check only 2 Medical Example)	niner: On the ba	asis of examina	wledge, deatl tion and/or in	n occurred at vestigation, i	t the time	e, date and inion, deat	d place, a	nd due to the	cause(s) date and	and manner place, and d	as stated. ue to the ca	ause(s)	
	To the within 2 To the Complet	Med	one)  29b. Signature and title of certifier,	and manr	ier stated.		29c.	License	number			29d. Dat	e signed (Mo	nth, Day, Y	'ear)	
	F 3 F 8			sh	Mun	<b>S</b>	N	00	378	21			9/	lou		
			30. Name and address of person who	completed caus	e of death (Item	23a) (Type.			10	-1		<del></del>	1/1/	/ /		
	H		John J. Goodill,					, Su	ite .	103,	Newark	, De	laware	1970	)2	
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 23:00 INA LEE SPATARO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SACRED CUMBER LAND ALLEGANY HEART HOSPITAL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. MAR 5 1918 5. Social Security Number Funera! 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🗓 F MARYLAND Director 217 18 4042 86 Usual Residence of Decedent 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits "naturel", or Items 23a or 28a-f show 1 Yes 2 No Director MARYLAND ALLEGANY FROSTBURG the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 16910 SPATARO LANE, NW 21532 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ont: If item 27 is marked other then "naturel", or Itel 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Ments litem 27 Is marked r other treumatic e ELIAS SKIDMORE IDA BELLE REPHORN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON KUHLMAN / DAUGHTER 13205 WOODRIDGE LANE, SW, CUMBERLAND, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Importent: If ite any injury or ot once. 1 

Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) FROSTBURG MEMORIAL PÁRK 9/4/04 FROSTBURG, MD 22. Name and Address of Facility 60 W. MAIN STREET SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RENAL ACUTE disease or condition resulting in death) ONE WEEK /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ UROSEPSIS 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? PARKINSONS DISEASE page 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DQA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 0 D33417 (MARRAND) SEPTEMBER 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 HIGHWAY LAVACE, MARTIAND 21502 MOEN, MO JAMES R 1068 NATIONAL 31. Date filed (Month, Day, Year) 32. Register's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 28 Year 10:45M Stern 08 Sarah Ann 04 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Allegany Heart Hospital Cumberland Sacred If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Apr 29, 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 9. Birthplace (State or Foreign 1 ☐ M 2 ☑ F ΜĎ Yrs. 215-20-7429 78 Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits Allegany Cumberland Yos 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 831 Windsor Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ann Frances (Danby) Williams Paul Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 833 Windsor Road Cumberland N 19a. Informant's Name/Relationship (Type, Print) ate, Zip Code) MD 21502 Paul Stern son Cumberland 20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 8/30/2004 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22. Nar</sup>Scarpeiii Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BACTERIAL PNEUMONIA WKS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Da Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown

Priysician /Medical **Examiner** 

Box 68760,

P.0.

Division of Vital Records,

**Physician** 

/Medical

10a State

MD

Director

by Funeral

Examiner

**Funeral** 

Director

itam 27 is markad other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at

parmit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural; or lien any injury or other traumatic event, the Medical Examinations.

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Examiner burial-transit ettending physician Physician/Medical use as the ŏ the detached been signed by þ Completed certificate has this Certification: After To the Hospital or Attending after death, Diractor: Aft

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC 25. Was case referred to medical examiner? Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of

OBSTRUCTIVE

29c. License number

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier bush curd

Medical Bldg.

29d. Date signed (Month. Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) Barrera Memoria

State Registrar 1 Natural

2 Accident

3 ☐ Suicide

29a Certifier

4 T Homicide

SFP 0 9 2004

5 Pending investigation

6 ☐ Could not be

determined

32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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P.O. Box 68760. Division of Vital Records,

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Baltimore, Maryland 21215-0036

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Dementia, Hypertension 25. Was case referred to medical examiner' 1 ☐ Yes 2 ▼ No 27. Manner of Death 1 X Natural 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5-04 1)0066036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1299 Lamberton Drive; Silver Spring, MD 20902 Mahmoud Doski, MD 31. Date filed (Month, 32. Begistrar's Signature oake **ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 Month **Physician** Richard Carl Schlenker August 2004 7:59 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Pennsylvania 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1<del>X</del> M 2□ F Days Min. Yrs. 192-14-4969 81 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County or 28a-f ahow 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 238 4112 Heathfield Road 20853 United States Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 □ No WW I I or Itema Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important; If item 27 ts marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Central Office Technician Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Schlenker Elsie Keiser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type, Print) Dale Schlenker /Daughter 1707 Merrifields Drive, Silver Spring, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 28, injury of 1 Burial 2 □ Cremation 3 □ Removal from State Parklawn Memorial Park 2004 Rockville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. any M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death **Physician** Coronary Atherosclerosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No has page 2 autopsy performed' certificate Division of Vital 1 ☐ Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 📉 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 X Yes 2 □ No this After this funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification; 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours a To the Funeral [ 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 57032 3+1 August 21, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6116 Executive Blvd. #155, Rockville, Maryland 20852 Gregory Kumkumian, M.D. 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature State AUG 23 2004

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Registrar

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α.	uires that signed b d be deta	by	Part II. Other sign	nificant conditions o	contributing to death I	but not resulting in the	underlying cause giv	ven in Part I.		obacco use cor Yes 2 🛛 No		he cause of death?
Records,	ne law requii has been s ge 2 should	Completed								rmed?	death?	opsy findings available impletion of cause of
Vital	icien: Th certificate rector, pag	e Cc	25. Was case ref	erred to medical				26. Place of Dea		2 X No	1 🗆 Yes	2 □ No
>	Physicien: The lithis certificate harral director, page	0 8	examiner?		Hospital: 1 ☐ Inpati	ient 2□ER/Outpatie	nt 3 DOA Ott	205			her (Specif	hospice
on of	ng Ph tter th neral	tion: T	27. Manner of De	5 Pending	28a. Date of Inj (Month, Da	ury 28b. Time ( ay Year) Injury	Wo			how injury occu		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: Attencompletely filled in by the fune	Certification:	2 Accident 3 Suicide 4 Homicid	6 Could not b	e 28e. Place of In	ijury - At home, farm, si tc. <i>(Specify)</i>	treet, factory, office		28f. Location ( City or To	Street and Num wn, State)	ber or Rura	al Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in I	edicai C	29a. Certifier (Check only one)			t of my knowledge, dea of examination and/or in tated.						
	To the Howithin 24 To the Fucomplete	Me	29b. Signature a	nd title of coeffice	11/	)	29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)
	- (			dela	Her		1	4121	8	8/2	010	4
	$\varphi$		30. Name and ac	Idress of person who	Completed cause of	death (Item 23a) (Type	, Print)				4	
			Charl	es Harri	son, MD	6001 Mur	ncaster	Mill Rd	Rock	ville,	Md	
	St Regist	ate rar	31. Date filed (M		32. Begist	rar's Signature	Sparks					

Charles Harrison, MD
31. Date filed (Month, Day, Year) 32. Degis AUG 25 2004

	,		For State	State of Maryland / I	Department of I		_		
			Registrer  1. Decedent's Name (First, Middle, Last)		Gorimoate of	Boain	Reg. 2. Date of Death	No. 2 0 0	3Time of Death
	Physici.	an	7 (	tun	S. 11.		A . 1	Day Yeer	0158 M
	/Medic		4a. Facility Name (If not institution, give s		4h City Town	or Location of Death	August i	21 205 4 4c. County of Deatl	
п	Examin	er	TI II	alcias Ilas at la	Rilia	\$ 60 C 11		4c. County of Deal	11
			5. Social Security Number 6. Sex	7. Age (In yrs. last bil	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Rief	holaca (State or Foreign
	Funeral Director			M 2∑F 47	Yrs. Months Days	Hours Min.	(Month, Day, Ye Sept. 3,	1956 MD	hplace (State or Foreign untry)
			Usual Residence of Decedent	+/			sept. 5,	1930   110	<u> </u>
	yland IOW		10a. State 10b. County	10c. City, Tow	m or Location				10d. Inside City Limits
	Mar	tor	MD Montgome	rv	Germantown				1 ☐ Yes 2 🔀 No
	r 28g	Director	10e. Street and Number	<del>-</del>	10f. Zip Code		10g.	Citizen of What Co	untry?
	h wit	ai D	19613 C Gunners Br	anch Road		20876	U <sub>1</sub>	nited Sta	tes
	deat	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of	Hispanic Origin? (Spe	cify Yes or No-	14. Race - Amer	
9	after or ite		1 Never Married 21 Married	1 ☐ Yes 2 X No If Yes, Give	1 Yes 2 No	an, Mexican, Puerto F	ncan, etc.)	Black, White	e, etc. hite
ğ	ral',	d by	3 Widowed 4 Divorced	Year or Dates:	TEL Tes 2 <u>M</u> NO	Specify:		Specify: W	III Ce
2	72 h	Completed	15. Decedent's Educ (Specify only highest grade	cation 16a	Decedent's Usual Occu (Give kind of work done	during most of working	16b	. Kind of Business/l	Industry
2	ithin ne.	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	nd)		Painters	Union
2	ygier ygier yer ti	S	12	As	ssistant to				OHIOH
Maryland 21215-0036	ould be filed within 72 hours after death with the Manyland Mental Hyglene. arked other than "natural", or Items 23a or 28a-f show atic event, The Maulical Examinat must be rediffed at	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			
<u>X</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "naturat, or items 23a or 28a-1 show any injury or other traumatic event, the Marical Examiner must be redifficed at once.	<sup>2</sup>	Paul V. Hoagland				ncis Cli		
Ja	2 sh and is m		19a. Informant's Name/Relationship (Type		. Mailing Address (Street				
	and tealth m 27 har tr		Charles G. Smith /		0613 C Gunne	The second second			
Baltimore,	Pages 1		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ R	amousi from State cemete	f Disposition (Name of ry, crematory or other pla	ice)		. Location - City or 1	Iown, State
E	Lant: Pa		' 4 □ Donation 5 □ Other (Specify)	Metrop	litan Crematory	August 20	04 <sup>3</sup> A		, Virginia
ă	permit. Departm Imports any inju		21. Signature of Funeral Service Lious	*/	22. Name and Addre	ess of Facility De	:Vol Fune	cal Home	, 10 East
_	Ø□ = € Ø		1 etch AS	Tu -	Deer Park	Drive, Ga	ithersbu	rg, MD 20	8//
П			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death. Do e cause on each line.	not enter the mode of dyi	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between
H	Physician		Immediate Cause (Final disease or condition	Palmonary by	nortensin				Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence					27,4076071
И	Examiner		Sequentially list conditions.	Mitral Stenos					unknown
	ש ש	iner	Sequentially list conditions, if any, leading to immediate cause. (Disease or injury	Due to (or as a consequence	of):				
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last						
Ö,	oe exection and a survival		resulting in death) cast	Due to (or as a consequence	01):				
8760	death certificate be executed e attending physician and od for use as the burial-transit	dicai	d						
9	eath certific attending p for use as t	Me	IF FEMALE:	2- 16					
Вох	ath c	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death		y		23d. Date of deli-	very Day Year
0	at the de by the a tached f	/sic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)				.,
۵.	hat the day	by Physician/Me	Part II. Other significant conditions con	tributing to death but not resulting i	n the underlying cause on	von in Part I	23a Did tobaco	o use contribute to	the cause of death?
Records,	The law requires that the ate has been signed by th bage 2 should be detache		11 if if if	tributing to death but not resulting i	ir trio driderlying cause go	ventuir cutti,	1 Tes		bably 4 Unknown
0	w require been sign	Completed	Hepahh)				1	2,40 00110	
ec	hysician: The law his certificate has t I director, page 2 s	npi					24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
		Co					performed 1XYes 2□		2 <b>2</b> No
Vita	cian sertifi ector	Be	25. Was case referred to medical examiner?	a anitali	200	26. Place of Death	(Check only one)		
	Physi this o	ို	1 195 25 190	ospital: 1 ■npatient 2 □ ER/Ou	ipatient 3 DOA			6 ☐Other (Spec	sify)
Ē	ing P	on:	27. Manner of Death 1 Matural 5 ☐ Pending		Time of 28c. Inju		8d. Describe how in	ijury occurred	
<u> </u>	tand leath tor: /	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			Yes 2□No			
Division of	or At fter o yirect in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, street, factory, office	2	81. Location (Street City or Town, St	and Number or Rui ate)	ral Houte Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,								
	Hosp 24 ho Fune Fune tely f	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of my knowledge ler; On the basis of examination an and manner stated.	e, death occurred at the ti door investigation, in my	me, date and place, a opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	thin 2 the the mple	Mec	29b. Signature and title of certifier	and manner stated.	29c. Licens	se number	29d. l	Date signed (Month	Day, Year)
,	F % F 8		111					_	
				- (BACOL MO		5-000		ust 21, 20:	
	15		30. Name and address of person who co	-1	(Type, Print)		S. 4 D /	L	1. 171207
	Sta	tá	31. Date filed (Month, Day, Year)	32. Registrar's Signature			c-neet bel	nmore, May	lane LICST
83	Registr		ALIC 2.4 20	04 Lesera	& South	61			
			MUU N I LU	V 1 /12" "	- popo o como	Car.			

			Please T					. Ensure A Health and I	_	<b>Are Legible</b> . iene	
			1 - State Registrar				tificate of			g. Nó.)	2071.0
	Physici		1. Decedent's Name (First, Middle, Last) Pearl K. Smith						2. Date of Death Month August	Day Year 20, 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town,	or Location of Death		4c. County of De	
	L.Xaiiiii	CI	Holy Cross Hospit				Silve	r Spring		Montgo	merv
Ŧ	Funeral		Social Security Number     6. Sex		e (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
	Director		578-05-7476	M 2004 F	88	Yrs.	Mortins Days	Hours Mill.	March 8,	1916 No	orth Carolina
	yland now		10a. State 10b. County		10c. City, 1	Town or Lo	cation				10d. Inside City Limits
	J within 72 hours after death with the Maryland jiene. Ithen - natural; or Items 23a or 28a-f show Ithe Mcdical Examinat must be molified at	tor	Maryland Montgom	ery	Silv	er Sp	ring				1 ☐ Yes 24(2)No
	in the	Director	10e. Street and Number				10f. Zip Code		10	og. Citizen of What 0	Country?
	th will	aiD	3114 Gracefield	Road, #50	7		20904			USA	
	ems ems	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. V	Vas Decedent of i	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerica <i>n</i> Indian,
õ	or It		1 Never Married 28 Married	1 ☐ Yes 2 🛣 N If Yes, Give	No		□Yes 2🍎 No		,	Specify: Wh	
2-003b	ural',	d by	3 Widowed 4 Divorced	Year or Dates:		10.0					
Ċ	n 72 n	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)		16a. Deced	lent's Usual Occu kind of work done	pation during most of wor ed)	king	16b. Kind of Busines	s/Industry
1212	within ene. than	шć	Elementary/Secondary (0-12)	College (1-4or 5	i+)		emaker	,		O II	_
N	9 7 9 7		17. Father's Name (First, Middle, Last)			HOIII	emaker	18. Mother's Nam	ne (First, Middle, M	Own Hom  Maiden Sumame)	le
a	d be antal	To Be	Thomas Kilpatric	k				Winefor	d Summer	lin	
<u> </u>	shoul nd Me mark imati	Ĕ	19a. Informant's Name/Relationship (Type			19b. Mailin	g Address (Street	1		City or Town, State,	Zip Code)
Ma	Ith ar Ith ar 27 Is r trau		Joseph A. Smith/		1						ng, Md 20904
<u>ნ</u>	permit. Pages 1 and 2 should be fill Department of Health and Menial Hill Important: If item 27 is marked oth any injury or other traumatic even once.		20a. Method of Disposition		20h Plac	ca of Dispo	sition (Name of	1	Date 2	20c. Location - City o	
more,	0 = = 5D		1 ☐ Burial 2X Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State			natory or other pla itan	Augu	st 22,	7	***
Balt	artm ortal		21. Signature of Funeral Service License	99 0 0	CI		. Name and Addre	ess of Facility			, Virginia
ñ	Per Per Per Per Per Per Per Per Per Per		1 (Inchew )	Cole						Home Inc.	ing, MD 2090
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	ations that caused	the death.						Approximate Interval Between
	Physician		Immediate Cause (Final								Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as			tenosis				Unknown
	Examiner			Congest		,	Failure				7 Days
		Jer	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as			Lullare				, Days
	outed id ansit	Examiner	Cause (Disease or injury that initiated events	Acute M	lyocar	dial	Infarcti	on.			Acute
ço,	be executed sician and burial-transit		resulting in death) Last	Due to (or as	a consequer	nce of):					
_		dicai	d	Coronar	y Art	ery D	isease				Unknown
X OX	law requires that the death certificates been signed by the attending phy 2 should be detached for use as the	Physician/Medi	IF FEMALE:	3c. If yes, outcome	of prognance						
X Q	attendation for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal de	eath 3	Ectopic pregnand	ry .		23d. Date of d	elivery Day Year
o i	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ U <i>n</i> known	4□Pregnant at 9□Unknown	line or deal	m 5_	Other (specify) _				
7.	w requires that the de been signed by the should be detached		Part II. Other significant conditions con	tributing to death b	ut not resulti	ing in the ur	nderlying cause gr	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ds	uires sign ld be	d by	Syndrome of ina	ppropriat	e ant	i-diu	retic ho	rmone	1 ☐ Ye	s 2 🛣 No 3 🗆 F	Probably 4 □Unk <i>n</i> own
Ö	w req bear shou	iete							24a. Was ar	24h Wara	autoney findings available
Vital Records,	sicien: The law certificate has b irector, page 2 s	Completed							autopsy	ned?   death?	
g	n: Ti ficate or, pa		25. Was case referred to medical								s 2 No
5	Physicien: r this certifica ral director,	o Be	eyaminer?	ospital:	ent 2 EF	2/Outpation	2000 Ot	h =	th (Check only one		
Ö	Phy ir this aral d	$\vdash$	27. Manner of Death	28a. Date of Injur	ry 25	8b. Time of	28c. Inju	4 Li Hursing H	28d. Describe ho	nce 6 Other (Sp w injury occurred	өсту)
Ö	iding fi th. : After s funer	ıtior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y Year)	Injury		rk? ]Yes 2 □ No			
DIVISION	Atter dea	ifica	3 Suicide 6 Could not be	28e. Place of Inju	ury - At home	e, farm, stre	eet, factory, office		28f. Location (Str	eet and Number or F	Rural Route Number,
É	a afte	Certification:	4  Homicide	building, etc	c. (Specity)				City or Town	, State)	
	To the Hospitel or Attending Pl within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	edical (	29a. Certifier 1 Certifying Phys	ner: On the basis of	f examination	edge, death n and/or inv	occurred at the ti	ime, date and place opinion, death occur	and due to the ca red at the time, da	use(s) and manner a te and place, and du	as stated. le to the cause(s)
	ro the vithin 2 on the complet	Med	29b Signature and title of certifier	and manner sta	ated.		29c. Licen	se number	29	d. Date signed (Mor	nth, Day, Year)
			12/00-	No.	10	DCC	D368	22		August 2	5, 2004
	12		30. Name and address of person who co	mpleted cause of d	leath (Item 2	(Type,	Print)			J	•
_			David Grossberg,	M.D. 2	2415 M	usgro	ve Rd.,	Silver Sp	ring, MD	20904	
	Sta		31. Date filed (Month, Day, Year)		ar's Signatur	re Zi	1	,			
	Registr	ar	AUG 2 6 2004	1 Smer	proset 1	D,	Sporks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yeer **Physician** August 23, 2004 1:00 Douglas Anthony Strobel /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Montgomery General Hospital Olney Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🕱 M 2 🗆 F 76 Director 578-34-0788 June 26, 1928 Washington, Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Maryland Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16828 Ethelwood Terrace USA 20832 Completed by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No II Yes, Give Korean Year or Dates: Confli Was Decedent of Hispanic Origin? (Specify Yes or No II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🙀 No 3 ☐ Widowed 4 ☐ Divorced Conflict 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Cartographer Publications t. Pages 1 and 2 should be filed value of Health and Mentat Hygie trant: If Item 27 is marked other to jury or other traumatic event, in filled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George C. Strobel Viriginia C. Waldsauer and 2.
.. of Health an ...ant: If tem 27 is ma. y injury or other tre-19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude M. Strobel/ Wife 16828 Ethelwood Terrace, Olney, MD 20832 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven 20a. Method of Disposition August 26 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 □ Donation 5 □ Other (Specify) 2004 Cemetery Silver Spring, Maryland permit. 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, Md 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MI Physician /Medical Due to (or as a consequence ol) Examiner Bleed nobable I Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the death certificate be executed ng physician and as the buriat-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 20 1 Yes 2 No 3 Probably 4 → Thknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed certificate 1 Yes 2 No Division of Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 2 ER/Outpatient Certification: To 1 Inpatient 3□ DOA this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Acciden within 24 hours after deal To the Funeral Director: 6 Could not be determined 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier npletely ( (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 1082039

State Registrar Mattheu

31. Date filed (Month, Day, Year) AUG 26

Prince Philip Dr. # 225 ane

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrary Signature

Eparado

			1- For State of Maryland / Department of Health and Months and Mon		ene	28751
	Physici /Medic		Charalas Tarais Characa	2. Date of Death Amonth August	Day 29 Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number)  Washington County Hospital  4b. City, Town, or Location of Death Hagerstown,		4c. County of Death Washing	
	Funeral Director		214-34-0123 A 73 Hs.	8. Date of Birth (Month, Day, Y	(ea <i>r</i> ) 9. Birti 1930 M	nplace (State or Foreign untry) D
	Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Washington Clear Spring,			10d. Inside City Limits 1 □ Yes 2 No
	with the ? 3a or 28e-	Funeral Director	10e. Street and Number 15223 Clear Spring Road 21722	10g	c. Citizen of What Co U.S.A	•
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28a-f show empty injury or other treumatic event, The Madical Examinational be notified at ance.	by	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes Sylve 1 Yes Sylve 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.
Maryland 21215-0036	d within 72 ho giene. er then "netur i the Modical.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  0  16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)  Farmers Helper	16	Sb. Kind of Business/I Farm	ndustry
/land	uld be file Mental Hy, arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) Charles Henry Sharon 18. Mother's Name Clara		iden Sumame) eth Patt	on
	and 2 sho salth and n 27 is ma		19a. Informant's Name/Relationship (Type, Print)  Gladys Whipp sister  19b. Mailing Address (Street and Number or Rural 19 W. Church St. Wi	Route Number, Cilliams	Dity or Town, State, Z port, MD	ip Code) 21795
Baltimore,	Pages 1 ment of He ent: If iter ury or oth		20a. Method of Disposition  **Burial 2 Cremation 3 Removal from State  **4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cametery, crematory or other place) Sept. 10c.  **Greenlawn Cemetery 200	f . 3.7	illiamsp	
Balt	permit. Departimport Import eny inj		21. Signature of Fineral Service in 1882. Signature of Fineral Service in 1882. Name and Address of Facility Donald Edwin Thom P.O. BOX 310 Clear	mpson F r Sprin	uneral H	ome,Inc
	Pnysician		23a. Part1. Enter thy disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or head failure. List only one cause on each line.  Immediate Cause (Final disease or condition	respiratory arrest	9, 110 0	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			
8760,	ate be executed thysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):			
P.O. Box 68	death certific e attending p id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   Mo   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9   Unknown		23d. Date of delia	very Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		2 DN6 3 □ Pro	the cause of death?
al Records,	The ate h page	Completed		24a. Was an autopsy performe	d? prior to co	opsy findings available ompletion of cause of
of Vital	Phys this al dii	: To Be			e 6 □Other (Spec	ify)
Division	or Attending fter death. birector: After n by the fune	Certification:	1 ⊠Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No		et and Number or Rui	ral Route Number,
7	To the Hospitel within 24 hours a To the Funeral Completely filled in	edical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, date	and place, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier  29c. License number  21 4 5 7	29d.	Date signed (Month)	Day, Year)
J.	19		29b. Signature and title of certifier  D21457  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ABOUL WAHERD WD _ 12-821 _ OAK H* I( AVE.  31. Date filed (Month PG Yegy) 1 2004  32. Pigistrar's Signature  S. Apull	HAGER	stown.	MD
	Sta Registr		31. Date filed (Month AUG Yes) 1 2004 32. Highster's Signature			

	SHOEMAKEK
04-5500	_
dap	1 _ For F

Amend Item #1 State of Maryland / Department of Health and Mental Hygiene trans

Certificate of Death

Reg. No. State Registrar

Death	3 Time of Death
Reg. No. 2004	2875

11:28p

1XYes 2□No

<b>Physician</b>
/Medical
Examiner

use as the burial-transit and ō detached signed by been page director death. hours after death uneral Director: the

Division of Vital Records,

Physician:

or Attending

**Funeral** Director the Maryland 27 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Exame ar must be notified at death v Funeral be filed within 72 hours after d Ital Hygiene. Id other than "natural", or Iten Baltimore, Maryland 21215-0036 þ Completed permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked other any injury or other traumatic event Be 2 **Physician** /Medical Examiner iner The law requires that the death certificate be executed Exam P.O. Box 68760,

Physician/Medical þ Completed Be Certification: in by within 24 hours a To the Funeral C

1. Decedent's Name (First, Middle, Last) 2. Date of D AUGUST 25, 2004 April Lynn Shumaker 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) HAGERSTOWN

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yept. 17)

Months Days Hours Min. Sept. 17 MARYLAND ROUTE 144 @ DELWOOD AVE WASHINGTON COUNTY Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 □ M 2 F 17 Maryland 212-13-8447 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21740 417 W. Washington Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dept. Store 12 Cashier 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Matti Jo Socks Gerald L. Shumaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 417 W. Washington St. Hagerstown Maryland 21740 Mary Ann Socks/Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sept. 1, 2004 Hagerstown Maryland Rose Hill Cemetery ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home uglas Na 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter tt. disease, or complications that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition Multiple 14 juries resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death?

examiner?

27. Manner of Death

1 Natural
2 Accident

(Check only

Day Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? Yes 2 No

1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1. Yes 2 □ No

25. Was case referred to medical 1 Yes 2 □ No

5 Pending

investigation

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 25/04

28b. Time of Injury 28c. Injury at Work?

1 ☐ Yes 2 🗷 No

26. Place of Death (Check only one

Other: 4 Nursing Home 5 Residence XX Other (Specify) SCF.NE 28d. Describe how injury occurred Possenger of a scooper struck by a

6 Could not be determined 3 ☐ Suicide 28e. Place o Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide street

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) Roufe 144 44 Dywood Ave, Hagerstown, MD

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

OCME

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 M Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

AUGUST 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month AUG 93) 1 2004

32. Pegistrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medicai

			For State	State of Ma	aryland /	,	rtment tificate				lental Hy		200	1 2	00750	
			Registrar  1. Decedent's Name (First, Middle, Las	))		Cer	uncate	OIL	Jealii		2. Date of D	Reg. No	LUU	l la	3. Time of Death	
	Physici		Arline Ma	•	Scara	no					Month	Da	•	Year	М	
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, T	own, or	Location of	of Death	Augu		c. County o	2004 of Death	1430 "	
			1	lemorial	Hosp	ita1		]	East	on			Tε	albo	t	
	Funeral		<ol> <li>Social Security Number</li> <li>Security Number</li> </ol>	x 7. Age	(In yrs. last	birthday)	If Under 1		If Under:		8. Date of B (Month, D	irth ay, Year			ace (State or Foreign	
	Director		140-10-7000	]M <u>2</u> √F	84	Yrs.					June 20	, 1920	)		Jersey	_
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Loc	cation							10	d. Inside City Limits	_
	Many f sho	ρ	Maryland Carol	ine	De	ento	n								1 ☐ Yes 2 No	
	r 28e	Director	10e. Street and Number				10f. Zip (	Code				10g. Ci	itizen of W	hat Count	ry?	_
et	death with the Maryland ms 23e or 28e-f show rn ust be notified at		9375 Mike Stree	t			216	529				Uni	ted	Stat	es	
ar.	ems ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. V	Vas Decede Yes, specif	nt of His	spanic Orig	gin? (Spe	cify Yes or N Rican, etc.)	0-	14. Race	- America		
368	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🙀 N If Yes, Give	ło		☐ Yes 2		Specify:		, ,		Specify:			
Mar 15-003	72 hours after death with the Marylar "naturel", or Items 23e or 28e-f show ofical Examiner must be notified at		3   Widowed 4 □ Divorced  15. Decedent's Ed	Year or Dates:	1 1	6a Docad	ent's Usual	Occupa	tion			16b k	Cind of Bus	Cauc	asian	
4) T.	in 72 " na" n	Completed	(Specify only highest grad	le completed)		(Give I life. D	kind of work OO NOT use	done di retired)	u <i>ring m</i> osi	t of worki	ing	100. r	and of bus	an essand	ustry	
in( 212	filed with Hygiene other ther ent, It e N	E O	Elementary/Secondary (0-12)	College (1-4or 5	+)	Hor	nemak	or						Home		
	be filed within 72 ho ital Hygiene. id other then "natur event, II e Modical	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	e, Maidei				
A1	uld b Menta arked	To E	John Phil	ip Heint	z. Sı	c			Chi	rist	ina T	ull	ock			
a,	2 should be filed within 72 hours after and Mental Hygiene. Is marked other then "naturel", or ite reumetic event, I'm Modical Examina.		19a. Informant's Name/Relationship (7				g Address (	Street a	nd Numbe	er or Rura	I Route Numi	ber, City	or Town, S	State, Zip (	Code)	
Scarano, Arl altimore, Maryland	s 1 and 2 should if Health and Mer item 27 is marke other treumetic		NormaS. Caccavale	Daught					le A		e, Fede					
Ar 2	Pages 1 nent of H ent: If ite ury or ot		20a. Method of Disposition 1  → Burial 2 ☐ Cremation 3 ☐		ceme	etery, crem	sition (Name natory or oth	er place	· .		ate		ocation - C			
ca	it. Pa ntmer rtent njury		<ul><li>4 ☐ Donation 5 ☐ Other (Specify</li><li>21. Signature of Funeral Service Licen,</li></ul>		Dent		Cemet Name and		_		2004	De	nton	, Ma	ryland	=
Ba	pernit. Pages Deportment of Importent: If it any injury or conce.			1/10				-		` 7 T	lome,	P.A	•			
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	Direction .		IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII												Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	a Due to (or as	a consequen		2 /	914	den	/				3	dry	_
6	Examiner		Commentally, link and distance	b. Hyps	cross,	0)								¥	MICI	
	p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to ar as	consequen	′ *	, .	11	*							
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or as	11/	Ca of):	brij	11	Te~						11911	
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687	icate phys s the	dlcal		d												-
×	leath certific attending p	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date	of deliver	v	
. Box	death e atte d for	Physiclan/Me	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pre Other (spe						Mont		Day Year	
0.	t the by the tache	hys	9 Unknown	9□ Unknown							-					
S,	res that the de signed by the a be detached t	by P	Part II. Other significant conditions of	ontributing to death bu	ut not resultin	g in the un	iderlying cai	use givei	n in Part I.						cause of death?	
ord	w requir been si should	ted									1 🗆	Yes 2	.□M6 3	B 🔲 Proba	biy 4 □Unknown	
ec	law i	Completed									24a. Wa auto	DDSV	24b. W	ere autopior to com	sy findings available pletion of cause of	
<u>=</u>		Co									pen 1 ☐ Yes	ormed?		eath? Yes 2	213-160	
Vit	icien certifi ector	Be	25. Was case referred to medical examiner?	Hospital:				-			(Check only					
ō	yd Sir	- To	1 ☐ Yes 2 ☑ No 27. Manne Leath	1 Inpatie		Outpatient b. Time of	3 □ DOA	c. Injury			ne 5 Res 28d. Describe					-
on	ding P th. After I	tion:	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year)	Injury	м	Work'	? ′es 2.⊟1			now inju	,, 0000,,0			
Division of Vital Records, P.O.	Atten r dea ector by the	ifica	3 Suicide 6 Could not be determined	288. Place of inju	ury - At home	, farm, stre	et, factory,	office			28f. Location	(Street ar	nd Number	r or Rural	Route Number,	-
Ö	s afte	Certificati	4 [] Hollicide	building, etc	с. (Ѕреспу)						City or To	own, Stati	3)			
	To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After the completely filled in by the funera		29a. Certifier 1 Certifying Ph	sician: To the best of	of my knowled	dge, death	occurred a	t the time	e, date and	d place, a	and due to the	cause(s	) and man	ner as sta	ted.	
	the hin 24 the F	Medical	one)	and manner sta	ited.	)										
	To To	<	29b. Signature and title of certifier	1/1			290.	License	number			ZBU. Da	ite signed	(wighth, D	ay, 1821)	
			30. Name and address of person who		ave	PM		15/	466			8/	150/	OY		_
			Ludwig Eglsed						_							
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	head	cnme	n's	Lan	e, ]	Eastor	1, M	aryl	and	21601	-
	Registr	ar	SEP 0 1 2004	AJENE W.	13.	The same of	C referen									

Physici	0.00	Decedent's Name (First, Middle, L.	ast)							<ol><li>Date of De Month</li></ol>	eath Dey	, ,	'ear	3. Time of	Death
/Medi		MATTHEW SKIDN	1ORE							AUG	29	200		23:2	0
Examir		4a. Fecility Neme (If not institution, gi		er)		4b. City	, Town, or	Location of	Death		4c.	County of	Deeth		
		311 WHITE OAK					ROSTI					ALLEG	ANY		
ineral ector		212 24 2314	1XIM 2FIE	Age (In yrs. 77	last birthday) Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da NOV 28	ay, Year)		Birthp Coun RYL		or Fore
_		Usuel Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							1	0d. Inside C	ity Lim
a Ca	ō	MARYLAND ALLEGA	1757		TDOOM	DIIDA								<b>X</b> XYes	
the Medical Examiner must be notified at	Director	MARYLAND ALLEGAI  10e. Street and Number	NI		FROST		ip Code				10a. Citi	izen of Wha	at Coun	ntry?	
2		311 WHITE (	OAK LANE				2153	32				U.S.		,	
=	Funeral	11. Marital Status	12. Was Decede	nt Ever in U	J.S. 13. V	Vas Dece	edent of Hi	ispanic Orig	in? (Spec	ify Yes or No		14. Race -	Americ	an Indian,	
No.	Fur	1 Never Married 2 Married	Armed Force		II "	Yes, spe	ecify Cuba	n, Mexican,	Puerto F	lican, etc.)		Black,	White,	etc.	
Exa	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	KOREA	AN 1	I ∐ Yes	2 <b>X</b> No	Specity:				Specify:	WH	ITE	
Ca	sted	15. Decedent's 8 (Specify only highest gi	ducation		16a. Deced	lent's Usu	ual Occupa	ation during most	of workin	a	16b. Ki	nd of Busin	ness/Ind	dustry	
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ber .		20a. Method of Disposition  1 ABurial 2 Cremation 3 [	☐Removal from Sta		Place of Dispos cometery, cren	sition (Na natory or	ame or other plac	e)	Da	ate	20c. Lo	cation - Cit	ty or To	wn, State	
lury		*4 □ Donation 5 □ Other (Spec			STBURG	MEM	ORIAI	PARK	9/1			TBURG			
any injury o		21. Signature of Funeral Service Lte	909 V	1				s of Facility				. MAI			
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Thomas A. Spivey, Sr. 19 1:43 P M Aug. 2004 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Cheverly Prince George If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 XM 2 ☐ F Yrs 578-34-8988 75 April 18, 1929 Washington, DC Usual Residence of Deceden 10c. City, Town or Location 10b. County 10d. Inside City Limits Prince George Clinton 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11316 Brandywine Road 20735 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2 XNo f Yes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker **USPS** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Clarence Spivey Sarah Gertrude Waldron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Spivey/Wife 11316 Brandywine Rd, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 № Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 8/24/04 Brentwood, MD 22. Name and Address of Facility Strickland Funeral Services 21. Sign yure of Funeral 6500 Allentown Rd, Camp Springs, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Coronary Artery Disease resulting in death) Due to (or as a consequence of) Old Myocardial Infarction if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c Diabeties Milliums Due to (or as a consequence of) <sub>d</sub>Pneumonia 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Obstructive Lung Disease 1 Yes 2 No 3 Probably 4 Unknown Hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 X No 1 Yes 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred М

Examiner Examiner use as the burial-transit The law requires that the death certificate be executed P.O. Box 68760. Completed by Physician/Medical jo ned by the a Records. page 2 of Vital or Attending Physician: Be After Division after death. by the f

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

Be

**Funeral** 

**Director** 

r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at

other than

Hygiene.

Pages 1 and 2 should be filed v timent of Health and Mental Hygie tent: If Item 27 Is marked other t jury or other traumatic event, in

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Importent: If Ite
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**Physician** 

/Medical

death v

filed within 72 hours after

Maryland 21215-0036

Baltimore,

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo Certification: To 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide 4 Momicide Medical 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29c. License number 20757 29d, Date signed (Month, Day, Year)

04

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 Hospital Dr, Cheverly, MD Dr. Arror Rao 31. Date filed (Month, Day, Year)

State Registrar AUG 2 7 2004

within 24 hours a To the Funeral I completely filled

To the

	7/2004	, 0		e of Maryland / Depa	artment of Health and trificate of Death	d Mental Hygi		0
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  NOYYIS  4a. Facility Name (If not institution, give street at	Thompson	4b. City, Town, or Location of De	2. Date of Death	Year 3. Time of Death  Year 11:49 A M  4c. County of Death	D I
	Funeral Director		5. Social Security Number 6. Sex 102534 154M 2D	7. Age (In yrs. last birthday) 90	If Under 1 Year If Under 24 F Months Days Hours M	8. Date of Birth (Month) Day,	rjear) 9. Birthplace (State or Foreign Country) Maryland	n
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Medical Examiner mast be notified at	ector	MD 10b. County Calvert	10c. City, Town or Lo  Dunki	rk		10d. Inside City Limits 1 ☐ Yes 2⊠No	
	eath with the 23a or 2	Funeral Director	12290 Long Leaf Lane	Decedent Ever in U.S. 13. V	10f. Zip Code 20754		g. Citizen of What Country?  USA	-
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2121	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or flems 23a or 28e-f show other than "natural", or flems 23a or 28e-f show event. Its Medical Examiner must be notified at	Completed	7	(Give life. L	ent's Usual Occupation kind of work doine during most of v OO NOT use retired) enance Engineer	vorking [	Board of Education Prince George's Co.	
Maryland	should be filed within nd Mental Hygiene. I marked other than umatic event, It o M	To Be		nompson	Sara		Swann	
	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or other treumatic anges.		19a. Informant's Name/Relationship (Type, Prin Brenda Wagner (daugh 20a. Method of Disposition	• I	g Address (Street and Number or  Long Leaf Lane	Dunkirk,	MD 20754	
altimore,	it. Pages rtment of I rtant: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal  4 ☐ Donation 5 ☐ Other (Specify)	from State Cemetery, crem Marylan	ad Veterans Aug	ust 24 004 Ci	nc. Location - City or Town, State	
Ba	Defini Depa Impo Any i		21. Signature of Funeral Service Licensee	8	125 Southern Ma	ryland Blvo	Home Calvert, PA d. Owings, MD 20736	
	Physician /Medical Examiner		23a. Part Finter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	crine mode of dying, such as card	CO 10V	Approximate Interval Between Onset and Death	
8760,	ate be hysici	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequence of): e to (or as a consequence of):				
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DIVISION	or Atten	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	Place of Injury - At home, farm, stre uilding, etc. (Specify)	M 1 Yes 2 No	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, state)	-
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	(Chack only 2   Madical Examiniter; On I	o the best of my knowledge, death ne basis of examination and/or inve manner stated.	estigation, in my opinion, death occ	curred at the time, date	and place, and due to the cause(s)	
,	T × T		1 Res	mD	29c. License number	1	Date sighed (Month, Day, Year)  8/19/2004	
5	+\ Sta			cause of death (Item 23a) (Type, R	DS planted,	Princeto	edards, m) 2267	3
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year CORNELIA. 2.20PM TAYLOR 23 04 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2🙀 F Director Yrs. 577-05-9591 July 17, 1916 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Itams 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Howard Fulton Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 12330 Scaggsville Road 20759 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: if itam 27 is marked other the any ijury or other traumatic avant, tha gonce. 12 Administrative Assistant Retail Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Lambert Taylor Minerva Christian Heil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 Russell Avenue, #212, Gaithersburg, MD 20877 Henry L. Taylor/ Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) August 30, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenwood ^ 4 □ Donation 5 □ Other (Specify) Trenton, New Jersey Como tory 21. Signature & Funeral Service Lie Francis J. Collins Funeral Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. Md 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardia Provsician 4 days /Medical Examiner Encephalops Sequentially list conditions Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 5 Other (specify) 4 Pregnant at time of death P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. bertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 ☐ Yes 2 14 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To tha P within 24 To tha F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/23/04. MD 20060345 10 KaisER A. Ahmad, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) atua xent Parkway LiHle Columbra

Registrar

31. Date filed (Month, Day, Year) AUG 25

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** August 19, рм William Edwin Teachum 2004 11:59 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year if Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 11, 1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**⊠** M 2□ F 579-07-0246 87 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location \*how 10d. Inside City Limits init. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artment of Heatih and Mental Hygiene ortent: if item 27 is marked other than "natural", or items 23a or 28e-f show mitty or either traumatic event, the Mudical Examinist must be rectified a new force. 1 Yes 2 No Directo Maryland Montgomery Wheaton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2812 Harris Avenue 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 v Yes 2 □ No If Yes, Give Year or Dates: 1941-45 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2K No White Specify: Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Government Elementary/Secondary (0-12) College (1-4or 5+) 12 Printer Printing Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Edward Teachum Marguerite Emma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances S. Teachum/ Wife 2812 Harris Avenue, Wheaton, MD 20902 Baltimore, 20b. Place of Disposition (Name of Carneler, crematory of other place)
Cemetery 20a. Method of Disposition 20c. Location - City or Town, Stete August 25 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department important: I any njury o 2004 Silver Spring, Maryland 1 4 □ Donation 5 □ Other (Specify) Francis descriptions Funeral Home Inc. 500 University Blvd., W., Silver Spring, Md 2090 21. Signatur on Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction 24 Hours /Medical Due to (or as a consequence of) **Examiner** Coronary Heart Disease Unknown Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner physician and the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760 use as IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) o. 1 Yes 2 No page 2 should be detached ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Urinary Tract Infection 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 Yes 2**X** No 1 🗌 Yes or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l in by t 4 - Homicide within 24 hours at To the Funeral D To the Hospitel filled 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HOSPITALIST 0+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natasha Lisa Chen, M.D. 9901 Medical Center Dr., Rockville, MD 20850 31. Date filed (Month, Day, Year) AUG 24 2004 32. Registrar's Signature oorked Registrar

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			For State Registrar	State of Mai		artment of I		nd Mental Hy	giene Reg. No: 10	
	Physici		Decedent's Name (First, Middle, Last					2. Date of De Month		Year 04 12:20 P M
	/Medic Examin		William Joseph Ta 4a. Facility Name (If not institution, give Calvert Memorial H	street and number)		4b. City, Town,	or Location of	Death	4c. County	of Death
	Funeral Director		5. Social Security Number 6. Se 213–12–1754	7. Age	(In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24		th ly, Year)	9. Birthplace (State or Foreign Country) Washington DC
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Calvert		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
	with the 3e or 28e	I Direc	10e. Street and Number	•	11(1110.4418	10f. Zip Code 206	39		10g. Citizen of W	Vhat Country?
036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "neturel", or items 23e or 28e-f show marked other then "neturel", or items 23e or 28e-f show matic event, the Medical Examinar must be rediffied at	by Funeral Director	1920 Quiet Meadows  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates:	rer in U.S. 13. 13. 1943 1945		Hispanic Origi pan, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)		e - American Indian, ck, White, etc. White
1215-0036	within 72 ho ene. then "netul te Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire Estate/Ba	during most o	of working		ge Company
Maryland 21	should be filed and Mental Hygi s marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) William H. Talbot				18. Mother	s Name (First, Middle, a Jackson	, Maiden Sumam	е)
	s 1 and 2 s if Health ar item 27 ls other treu	College and Colleg	19a. Informant's Name/Relationship (T.  Marion V. Talbott  20a. Method of Disposition 1 □ Burial 2 ♀ Cremation 3 □ I	(Wife)	lan v	Quiet Mes	dows C	or Rural Route Number Ourt Hunt i	ingtown.	And a second of
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Fire at Savic Condition 1.	)		2. Name and Addr	ess of Facility		al Home (	on MD Calvert P.A. gs MD 20736
100	Pnysician /Medical	The state of the s	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Staply (	ne death. Do not ent	ter the mode of dy	ing, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
B	Examiner	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(ica	consequence of):	extren	miti'e	5		several ment
8760,	icate be executed physician and s the burial-transit	dical	that initiated events resulting in death) Last	U	consequence of):	- Syn	droma	J		1-2 weeks
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and toge 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic pregnand □ Other <i>(specify)</i> _	y		23d. Date Mor	e of delivery nth Day Year
ords, P	w requires that been signed b should be deta	by	Party Other significant conditions co	entributing to death but	not resulting in the u	nderlying cause gr	ven in Part I.			ibute to the cause of death? 3 Probably 4 Monknown
al Record		Completed	Dementia					24a. Was autor perfo 1 Yes	psy pormed? d	Vere autopsy findings available prior to completion of cause of leath?
on of Vital	Attending Physicien: The r death. ector: After this certificate his by the funeral director, page	ion: To Be	27. Mann r of Death 1 Vatural 5 Pending	Hospital: 1 patient 28a. Date of Injury (Month, Day)	28b. Time o	f 28c. Inju	her: 4 🗆 Nurs			
Division of	tel or Attendi s after death el Director: A ed in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		y - At home, farm, str (Specify)					er or Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Directompletely filled in by	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	ysician: To the best of iner: On the basis of e and manner state	xamination and/or in	vestigation, in my	opinion, death	place, and due to the occurred at the time,	cause(s) and mar date and place, a	nner as stated, and due to the cause(s)
•	To t To t	Σ	29b. Signature and title of certifier	MO		29c. Licen	se number		8 (24	(Month, Day, Year)
1	4+1		30. Name and address on person who co	no 10	ण Hosely 0		Prince	e Freders	ck, m	0 20678
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2	32. Registra	Signature &	fresh	ø			

		1	State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygiene
	+		Decedent's Name (First, Middle, Last)		2. Date of Death 3. Time of Death Month Day Year
	Physicia /Medic		Sharon P. Torrence		August 22, 2004 0300 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	- //
			4216 Vine Street	of If Under 1 Year I If Under 24 Hrs.	8. Date of Birth 9. Birthplece (State or Foreign
	Funeral Director		5. Social Security Number  6. Sex  1 \( \text{N} \) M 2\( \text{N} \) F  7. Age (In yrs. last birthda 51 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year)  Aug. 24, 1952  9. Birthplece (State or Foreign Country)  Washington,DC
			Usual Residence of Decedent		
	nylan thow		10a. State 10b. County 10c. City, Town or		10d. Inside City Limits 1X Yes 2 □ No
	8a-f	Director		Heights	10g. Citizen of What Country?
	with ti	吉	10e. Street and Number 4216 Vine Street	10f. Zip Code 20743	
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (S	DECITY Yes or No- 14. Race - American Indian,
			Armed Forces?  1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No Specify:	
2-003e		d by	3 Widowed 4 Divorced Year or Dates:		Specify: Black
7	72 nat	Completed	(Specify only highest grade completed) (Gi	edent's Usual Occupation ve kind of work done during most of wor . DO NOT use retired)	king 16b. Kind of Business/Industry
7	within iene. then "	фшо	Elementary/Secondary (0-12) College (1-4or 5+)	gement Analyst	U.S Dept. of Agricult.
D	Hygin other	BeC	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Sumame)
land	should be nd Menta marked umatic ev	ToB	James Torrence	Juli	a White
Mary	2 sho				ral Route Number, City or Town, State, Zip Code)
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	-	20a Method of Disposition 20b. Place of Dis	83 Maxwell Ct. Lau	Date 20723  Date 20c. Location - City or Town, State
וסק	0 = 5		TS Burial 2 □ Cremation 3 □ Removal from State  * 4 □ Dopation 5 □ Other (Specify).  **Cemetery, c Harmony	rematory or other place) Mem. Pk 8/3	Bl/04 Landover, MD
altimore,	그 든 본 분		4 Donador 9 Donat (objectiv)	1	rickland Funeral Services
ñ	Depa Depa Impo any ir		V "/// VV ///		Camp Springs, MD 20748
Ť			23a, Part. Enter the disease, or complications that caused the death. Do not on shock or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	c or respiratory arrest, Approximate Interval Between
7:	Physician		Immediate Cause (Final disease or condition a Arteroscl eute	c Hypertheine	Heart Disease
100	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	,,,	
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
	uted d ansit	Examiner	causé. Enter Undertying Cause (Disease or injury that initiated events  c.		
oʻ	an an		resulting in death) Last Due to (or as a consequence of):		
8760	certificate be executed uding physician and use as the burial-transit	dicai	d		
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Вох	ath itter	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3 □Ectopic pregnancy 5 □ Other (specify)	Month Day Year
o.	0 0 0	hysi	1 Yes 2 No 9 Unknown		
S, G	S 7 0	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ord Ord	w require been sig should b				1 Yes 2 No 3 Probably 4 Onknown
Records,	e law r has be je 2 sh	Completed			24a. Was an autopsy prior to completion of cause of death?
					1 Yes 2 No 1 Yes 2 No
Vital	siciar certif recto	o Be	25. Was case referred to medical example ?  Hospital: 1 Inpatient 2 ER/Outpa	Other	ath (Check only one)  Home 5⊟ Residence 6 □ Other (Specify)
Division of	Attending Physician: r death. sctor: After this certific by the funeral director,	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how injury occurred
ion	andini ath. or: Aft	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	
Σ	or Attender de Diracto in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Hospital ( 4 hours at Funeral D		29a. Certifier 1 Certifying Physician: To the best of my knowledge, do	eath occurred at the time, date and place	a. and due to the cause(s) and manner as stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	Medical	(Check only 2 Medical Exeminer: On the basis of examination and/o one) and manner stated.	investigation, in my opinion, death occu	urred at the time, date and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			I falorda Bhother so	H0055929	Hugust 25, 2004
C	R (7)		30. Name and address of person who completed cause of death (Item 23a) (Ty)	lospital Drome,	Charaly arrang law of
	Sta Regist		31. Date filed (Month, Day, Year)  22. Registrar's Signature	all )	//

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ORIGINAL

			1 - For State Registrar	State of	f Maryland	-	artmen rtificat				lental Hy	gien Reg. N	00	Ω L	28761
	Dharia		1. Decedent's Name (First, Middle, L	.ast)							2. Date of De	eath	ay	V	3. Time of Death
	Physici /Medi		JOSEFA ALBERT	CINA VE	LEZ						AÜĞÜS			2 0 0 4	9:44 PM
	Examir		4a. Facility Name (If not institution, g		•		4b. City,	Town, or	Location	of Death		40	c. Count	ty of Death	·
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	Funeral Director		5. Social Security Number 6. 230-19-2512  Usual Residence of Decedent	Sex 1☐M 2XIF	7. Age (In yrs. Ia:	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D. Aug. 7	ay, Year	924	9. Birthp Cour Colu	
	fand ow		10a. State 10b. County		10c. City,	Town or Lo	cation							1	0d. Inside City Limits
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	r 288	Funeral Director	10e. Street and Number	ICK	wal	KELSV	10f. Zip	Code				10g. C	itizen of	What Cour	Λ
	h witi	0	228 Glade Blvd.	*				21	.793				USA		,
	deat ms 2	Jer	11. Marital Status	12. Was Dece	dent Ever in U.S.	. 13.	Was Deced			gin? (Spe	ecify Yes or No Rican, etc.)	D-		ce · Americ	an Indian,
9	after or Ite	3	1 Never Married 2 Married		2 No	1	_							ack, White,	etc.
8	ours	d by	3x Widowed 4 □ Divorced	If Yes, Giv Year or Da	ates:		XXYes 2	2 L NO	Sреспу:	Colum	nbian		Speci	<sup>fy:</sup> Wh	ite
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2	12 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Exametrizat be notified at		17. Father's Name (First, Middle, Las	241		Hom	emake	r	10 11-11-		/ <del>=</del> *		vn H		
and	be f ntal H ed of	Be		•				İ			(First, Middle	, <i>Maid</i> er	n Suma	me)	
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Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinator usit be notified at	6 1			1						l Route Numb				Code)
	1 and 2 Health em 27	11.3	Judy Basham, Gran	ıddaught	er 20b. Plac	228 ce of Dispo	Glade	31v	d., 1	dalke	rsvill			1793 - City or To	um Ctata
JOI	00		Magarial 2 ☐ Cremation 3	Removal from S	Julio	ce of Dispo								-	
altimore,	permit. Pag Department mportant: I any injury o		4 ☐ Donation 5 ☐ Other (Spec	ity)	NCT.	Memo				28-20				hurch	, VA
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	_		23a. Part1. Enter the disease, or cor	molications that ca	sused the death.	/	482 L	ее н	WY Fa	ILLS	Church	• VA	22	042	Approximate
			shock, or heart failure. List onf Immediate Cause (Final	y one cause on ea	ach line.					ourale o	r respiratory a	11031,			Interval Between Onset and Death
}	Physician /Medical		disease or condition resulting in death)	aC	medeo fu	LWUM	BY BY	21250	T.						< 1 HOAR
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		e.	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a conseque		Cardi	LYKKU	M D	Beny	oC.	-			and the second
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events												
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89	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Medi	15.551.11.5												
Вох	eath certific attending p for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregnance		Ectopic pre	ananev					23d. Da	ite of delive	ry
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ord	w requir been si should I										10	Yes 2	<b>⊘</b> No	3 Proba	ably 4 □Unknown
of Vital Records,	law r as be	Completed									24a. Was		24b.	Were autop	sy findings available
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ita/	iffic or,	Be (	25. Was case referred to medical examiner?						26. Place	of Death	Check only o				70
Ť	hysicle his cert I direct	ဂ္	1 ☐ Yes 2 ☐ No			VOutpatien	t 3 🗆 DO	A Othe	r: 4 🗆 Nui	rsing Hom	ne 5 🗀 Resid	dence	6 🗀 Oth	er (Specify)	)
		on:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of (Month	f Injury 28 n, <i>Day Year</i> )	8b. Time of Injury	28	Bc. Injury Work	at ?	2	8d. Describe I	now inju	y occur	red	
Sio	Attending r death. sctor: After by the fune	catl	2 Accident investigate	ho			M	1 🗆 Y	es 2□N	No					
Division	or Attendation of the or deat of the or deat in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determined	286. Place	of Injury - At home g, etc. <i>(Specify)</i>	e, farm, stre	eet, factory,	office		2	8f. Location (5 City or Tox	Street an vn. State	d Numb	er or Rural	Route Number,
	ospital of hours at uneral Dun	ပ္													
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	To the within 2 To the complet	Ž	29b. Signature and title of certifier	(1)			29c.	License	number			29d. Dat	- 4	d (Month, D	lay, Year)
in .			1 260	XX				DS	207	-			8/2	1/04.	
		1	30. Name and address of person who		of death (Item 23										
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Raymond

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 2, 200°4 **Physician** Harry Wood 11:20 p<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 471 Paradise Road Aberdeen If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 12/20/34 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1⊠M 2□F 69 New Jersey 140-26-3761 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-f show the Medical Examiner must be notified at Yes 2 No MD Harford Havre de Grace Directo 10g. Citîzen of What Country? 10f. Zip Code 10e. Street and Number 21078 U.S.A. 724 Green Street 238 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify:White Completed by 3 ₩idowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Heavy EquipmentSuperintendant Construction 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event <u>once.</u> Be Esther Sayers Harry Wood, Jr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Jean Leonetti (Sister) 724 Green Street, Havre de Grace, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 【 Removal from State 9/7/04 Seaside Crematory Marmora, NJ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pulmorary Fibrosis I Lion athic Immediate Cause (Final 5 years Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Englishment or injury Due to (or as a consequence of): Examiner The taw requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, NIDOM 2 No 3 Probably 4 Unknown artery discase 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 ☐ Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) nephlws Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 2 No Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 9/3/04 20004805C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 South Parke Street Aberdeen MO 21001 MO Prashant 31. Date filed (Month. State 9 2004 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State		State	of Mar	yland /	•	irtment of H <i>tificate of L</i>		and Me		giene Reg. No		
			1. Decedent's Name	e (First, Middle, L	ast)				imouto of L			2. Date of De	ath	2004	3. Time of Death
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	Funera		5. Social Security N		Sex 1□M 2□F		'in yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da MARCH	th ly, Year)	9. Birth	place (State or Foreign intry) <b>YORK</b>
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36	be filed within 72 hours after death with the Maryla half Hygiene.  Identified the "natural", or Items 23a or 28a-f show a other than "natural", or Items 23a or 28a-f show a sant, I're Maxilgal Ex. nitrer a unit be notified all	by F	3 Widowed		If Yes, Gi Year or D	ive		1	☐ Yes 2X No	Specify:				Specify:	WHITE
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State of Maryland / Department of Health and Mental Hygiene

			Certificate of Dea	th	Reg. No. 2070
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- Car		Maplewood Park Place		hesda	Montgomery Co.
	Funeral Director	5. Social Security Number 6. Sex 1 ★ M 2 □ F 7. Age (In yrs. Ia. 180 − 32 − 8568 91	st birthday) If Under 1 Year If Un Months Days Hou	der 24 Hrs. rs Min. 8. Date of Birt (Month, Da) Oct. 5	9. Birthplace (State or Foreign Country) Romania
	pue 👔	Usuel Residence of Decedent  10a. State 10b. County 10c. City,	Town or Location		10d. Inside City Limits
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	the 28e	Maryland Montgomery Co. Beth	lesda 10f. Zip Code		10g. Citizen of What Country?
	3a or	9707 Old Georgetown Road	20814		U.S.A.
	death	11. Marital Status 12. Was Decedent Ever in U.S.		Origin? (Specify Yes or No-	
Maryland 21215-0020	s 1 and 2 should be filed within 72 hours after death with the Meryland Haalth and Mental Hygiene.  Item 27 is marked other than "natural", or flems 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	Armed Forces?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes 2 ☑ No If Yes, 6 ive Year or Dates:	If Yes, specify Cuban, Mex		Black, White, etc.  Specify: White
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Baltimore,			netery, crematory or other place) opolitan Cremator	v 8/20/04 A	Alexandria, Virginia
≣	permit. Page Department of Important: If any Injury or once.	21. Signature of Funeral Service Licensee	22. Name and Address of Fe		
B —	en de de de de de de de de de de de de de	Robert E Evans	5755 Castlewel	lan Dr. Alexa	Funeral Chapel andria, Virginia 22315
	-	23a. Part1. Enter the disease, or complications thet caused the death. shock or heart failure. List only one cause on each line.	Do not enter the mode of dying, such	as cardiac or respiratory en	rest, Approximate Interval Between Onset and Death
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	To the Ho within 24   To the Fu completel	29b. Signature and title of certifier	29c. License numbe	er 2	29d. Date signed (Month, Day, Year)
	- s - ô	Merley Venus	MW1 D25	791	8/18/000
	22	30. Name end address of person who completed cause of death (from 2	3e) (Type, Print)	- //	7/10/7
	20	MURMURY MD. 9601 GEL 31. Dete filed (Month, Day, Year) 32. Registrar's Signatur	DRGIA AVE	SILVERS	PRING ND 20902
	State Registrar	ALIC 2 4 2004	& sporker		

WEISELBERGY, MIRIAM

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			For State Registrar		State of M	arylan	-	artment of F <i>rtificate of</i>	leaith and N <i>Death</i>		giene Reg. No	200	2976
			1. Decedent's Name	(First, Middle, La	ist)					2. Date of Dea	ıth		3. Time of Death
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ì	Examin		4a. Facility Name (If	not institution, giv	re street and number)			4b. City, Town, o	r Location of Death		40	. County of Deal	th
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h the	128	Director	10e. Street and Num					10f. Zip Code			10g. Ci	tizen of What Co	puntry?
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r dea	E JE	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		14. Race - Ame Black, Whit	
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3	othe othe	Be C	17. Father's Name (	First, Middle, Last	)				18. Mother's Name	e (First, Middle,			
4 P	Aenta rkad tic ev	To B	Moses	Sch	indler				Netty		Pec	hter	
shoi	e me		19a. Informant's Na	me/Relationship (	Type, Print)		19b. Maili	ng Address (Street	and Number or Rura	al Route Number	r, City o	or Town, State, 2	Zip Code)
and	Department of Heelth and Mental Hygiene. Importants: If Item 27 is marked other than "natural", or items 23s or 28s-f show many injury or other traumatic event, this Mudical Examinat must be notified at once.		Shelley F	inger, d	aughter		3725	Equinox V	Vay, Dumf	ries, VA	2	2066	
es -	of He		20a. Method of Disp		Bemoval from State	20b. P	lace of Dispo emetery, crea	osition (Name of matory or other place	(8)	Date	20c. L	ocation - City or	Town, State
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or Attending	deatn. ctor: After y the funer	atlo	1 Natural 2 Accident	5 Pending investigatio	(Month, Da	y rear)	Injury	Worl M 1 □	Yes 2 □ No				
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ta o la	rs arr ai Di	Cer		. /	Building, co	o. (Opecny	/			Only or TOW	, Olale	/	
deo	uner uner	edical	29a. Certifier (Check only	1X Certifying Ph 2 Medical Exam	nysician: To the best miner: On the basis of	of my knov	wledge, death	occurred at the tin	ne, date and place, a	and due to the ca	use(s)	and manner as	stated.
To the Hospital or	witnin 24 hours after o <b>To the Funeral Direc</b> completely filled in by	Med	one) 29b. Signature and t		and manner sta	ated.							* *
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	4		X	11	1	7	***		, , , ,	1	14	Gus7	20,2000
	4		30. Name and addre	ss of person who	EL M	eath (Item	a) (Type,	Mon/-	Tarrell	on Ra	71.	L/Level	MDDOR
	Sta	te	31. Date filed (Month	n, Day, Year)	/ 32. Registra	ar's Signat	ure	1 - (1	110121	4	ر بر ر	VICT	Day, Year) 20, 2006 ND 2085
	Registra		А	UG 24 2	2004 220	war	19	Spark	2				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death (3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 23 2004 NORMAN WILLOUE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Casey House | House 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 26. 19 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1⊠M 2□F 1918 127-01-8409 85 Director Usual Residence of Deced 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1√2 Yes 2 □ No Maryland Silver Spring Montgomery Direct the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number WE 3310 N. Leisure World Blvd., # 520 20906 U. S. A. death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1∑IYes 2 □ No Army If Yes, Give Year or Dates: WW 2 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or item ony injury grother traumatic event, the Madical Eventuarians. 1 Never Married 27 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or5+)
4 Years Elementary/Secondary (0-12) Vice-Pres -Tapetex Company Textiles 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dora Wilcove Moses Wilcove 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) # 520, 3310 N. Leisure World Blvd., Maryland 20906 Edna G. Wilcove - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Falls Church, Virginia 8/24/2004 National Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland Hottlemyer Donald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Renal Disease Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and use as the burial-trar Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day jo in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? been signed the should be detected to the should be detected to the should be detected to the should be sh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by Hemmorage Radiation Cystitis 1 Yes X No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2**X** No 1 🗌 Yes certificate of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence Other (Specify) Hospice 2 ER/Outpatient 3 DOA 1 ☐ Yes 2X No 은 funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; After Division 5 Pending 1 X Natural s after dec. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 | Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tipe of certif 00041218 12 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 6001 Muncaster Mill Road, Rockville, Maryland Charles Harrison, M. D. 31. Date filed (Month, Day, Year) AUG 24 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

oaks

			<ul> <li>Registrar</li> </ul>		of Maryland / De LII, 25, 27, 28	eruncate of	Dealli		Reg. No:	14 2876					
			1. Decedent's Name (First, Mic	ddle, Last)				2. Date of De	eath Day	3. Time of Dear					
	Physici /Medio		Walter H. W:	innard, J	r.				21, 20	04 5:30 P					
	Examir		4a. Facility Name (If not institut	tion, give street and n	umber)	4b. City, Town, o	or Location of De	eath	4c. County	of Death					
			Montgomery (	General Ho	spital	Olney			Mon	tgomery					
	Funeral		5. Social Security Number	6. Sex 1 <b>⊠</b> M 2 □ F	7. Age (In yrs. last birthd	Months Days		in. (Month, Da	ıv, Year)	Birthplace (State or For Country)					
	Director		017-16-9708 Usual Residence of Decedent		81 Yrs			Feb. 6,	1923	Massachusett					
	land land		10a. State 10b. Cour	nty	10c. City, Town or	Location				10d. Inside City Lin					
	Mary H sh	ō	Maryland Mon	ntgomery	Silver	Spring				1 ☐ Yes 2√					
	28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?					
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	deat deat	Funeral	11. Marital Status		cedent Ever in U.S. 1	3. Was Decedent of H	lispanic Origin?	(Specify Yes or No		e - American Indian,					
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Is marked other than "neturel", or Items 23s or 28s-4 show other treumatic event, I'm Medical Examinatings the rolling at	by	1 ☐ Never Married 2 ☑ M 3 ☐ Widowed 4 ☐ Divorc	arried 1 TYes	2 □ No Bive WWTT	If Yes, specify Cuba 1 ☐ Yes 2 🙀 No	an, mexican, Pu Specify:	erto Hican, etc.)		k, White, etc. White					
2-0	72 ho	Completed		ent's Education hest grade completed	16a. De	cedent's Usual Occup		work in a	16b. Kind of Bu	isiness/Industry					
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yla	Men Men arke	9	Walter H. Wir	nnard			Blanc	he Robarc	re						
, Maryland	and 2 sho alth and 127 Is m Br treum		19a. Informant's Name/Relation Phyllis Winnam		19b. Ma 350	ailing Address <i>(Street</i> L Forest Ed	and Number or ge Dr. E	Rural Route Number 81dg. #14-	er, City or Town, -2C, Silv	State, Zip Code) ver Spring , MD 209					
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is eny injury or other tree	1	20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other		20b. Place of Dis cemetery, of Gate of	position (Name of rematory or other plac f Heaven	<sup>сө)</sup> Aug	gust 25,	20c. Location -	City or Town, State					
Balti	permit. Departm Importe eny inju		21. Signature of Runeral Service			tery 22 Name and Addre Francis J 500 Univer		2004 ns Funera vd. W S	l Home S	pring, Maryla Inc. pring, MD 209					
			( )	or complications that						Approximate					
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	/Medical Examiner		resulting in death)												
		_	Sequentially list conditions,	b. Obst	truction of a	Obstruction of airway by food particle									
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ı	Physic		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month AUGUST	h	3. Time of Death  11:46 PM
	/Medi Examir		RONALD J. WOLF  4a. Facility Name (If not institution, give street and number)  UNIVERSITY OF MD SHOCK TRAUM	IA	4b. City, Town, or Loc BALTIMOR		AUGUST	4c. County of Death	11:40 P
	Funeral Director		5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 42	n yrs. last birthday) Yrs.	If Under 1 Year   If I	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, JUNE 25	Year) Coul	place (State or Foreign htry) ISYLVANIA
	the Maryland 28a-f show	tor		oc. City, Town or Lo	cation				0d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with the a or 28s	Direc	10e. Street and Number		10f. Zip Code			0g. Citizen of What Coul	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Exprise retinus Le rivillisal at	by Funeral Director	615 TIMBER WOOD BOULEVARD  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		19702 Was Decedent of Hispar f Yes, specify Cuban, M 1 ☐ Yes 2⊠ No Sp	nic Origin? (Specilexican, Puerto F	cify Yes or No-	UNITED STAT  14. Race - Americ Black, White,  Specify: WHI	ean Indian, etc.
21215-0036	72	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done durin DO NOT use retired) HANIC	n ng most of workin	g	16b. Kind of Business/in HEALTH CAR	dustry
Maryland 2	und be filed Mental Hyg irked other itic event,	To Be C	17. Father's Name (First, Middle, Last) STANTON WOLF		18.	Mother's Name		Maiden Sumame)	
Mary	id 2 sho Ith and P 27 Is ma trauma		19a. Informant's Name/Relationship (Type, Print) SHERYL A. WOLF/WIFE		g Address (Street and I	Number or Rural	Route Number,	City or Town, State, Zip	30.
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event. It is ware once.			20b. Place of Dispo			T 28,	JARK, DELAWA 20c. Location - City or To JIDDLETOWN,	wn, State
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee	22 H.	Name and Address of ICKS HOME F 03 W. STOCK	Facility OR FUNEI	RALS, P. EET, ELF	.A. KTON, MARYL	
	Physician physician and physician and physician and the prinal-transit street physician and physicia	dical Examiner	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate ease. Enter unscriying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition or condition	insequence of):	om nel i	Jun 18		IST,	Approximate Interval Between Onset and Death
O. Box 6	ne death certifithe attending the defenders	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
Δ,	v requires that the been signed by should be detact	by	Part II. Other significant conditions contributing to death but no	ot resulting in the ur	nderlying cause given in	Part I.	23e. Did tob	acco use contribute to th	
œ	The law ate has b page 2 s	Completed					24a. Was an autopsy perform	prior to cor ed? death?	psy findings available inpletion of cause of
f Vital	Physiclen: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1   ✓ Yes 2   No   Hospital: 1   Inpatient	2 KER/Outpatien	Othor	Place of Death		nce 6 ☐Other (Specify	)
	Jing After fune	Certification:	27. Manner of Death  1 Natural  SAccident investigation  3 Suicide 6 Could not be	1 7:00	PM 28c. Injury at Work? 1 □ Yes	2 No 0	Bd. Describe how	winjury occurred Ki	invited
Divi	o # 등 =		4 Homicide determined 286. Place of Injury - building, etc. (S	pecity)	2	a	000 000	60 41	2
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or inv	estigation, in my opinior	n, death occurred	d at the time, da	te and place, and due to	the cause(s)
)	co d will	2	29b. Signature and title of certifier	Ol-n	O C M			d. Date signed (Month, I AUGUST 24,	
	10		39. Name and address of person who completed cause of death	(Item 23a) (Type,	Print) 111 Penr	n Street	, Balti	more, Maryl	and 21201
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 6 2004	Signature Appen	W				

		For Stata Registrar	State of Marylan		artment of H		Reg	ene . No.2 0 0 L	28770
Physicia	an	Decedent's Name (First, Middle, Las     TADIT					2. Date of Death Month	Day Yea	
/Medic		EDWARD JARV  4a. Facility Name (If not institution, give			Ab City Town or		AUG. 25,		8:00 A
Examin	er	416 GEORGE ST.	street and municery			Location of Death		4c. County of D	eath
Funeral		5. Social Security Number 6. Se		last birthday)	If Under 1 Year	PEAKE CIT If Under 24 Hrs.	8 Date of Birth	CECIL 9.1	Birthplace (State or Forei Country)
Director		221-38-8424	X M 2□F 46	Yrs.	Months Days	Hours Min.	(Month, Day, Y	958	DE
pus *	}	Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	acation		27/2		
72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dical Examiner must be notified at	ō	MD CECIL			ESAPEAKE (	CTTY			10d. Inside City Limi
the ?	rect	10e. Street and Number			10f. Zip Code		100	. Citizen of What	
23a or	id	416 GEORGE ST.				1915	109	USA	oodiniy.
s 1 and 2 should be filed within 72 hours after death with fleatith and Mental Hygiene. The fleatith and Mental Hygiene flean 27 I amerkad other than "natural", or Items 23a or other traumatic avant, the Medical Examinational be	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H		ecify Yes or No-	14. Race - A	merican Indian,
after or Ite	/Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		ir Yes, specify Cuba 1 □ Yes 2 🛣 No	in, мехісап, Риепо Specify:	Hican, etc.)	Black, W	
72 hours after dea "natural", or Items deal Examination	d by	3 ☐ Widowed 4 M Divorced	Year or Dates:		1 163 2 A 140	эрөспу.		Specify:	NHITE
"nat	Completed	15. Decedent's Edi (Specify only highest grad		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of work	ing 16	b. Kind of Busine	ss/Industry
within ene. than "	шc	Elementary/Secondary (0-12)	College (1-4or 5+)		BUTION SI	<b>'</b>		DEMATE (	1 A T TIO
filed Hygie other ant, III		17. Father's Name (First, Middle, Last)	1	DISTRI	DOLLON SI		e (First, Middle, Ma	RETAIL S	DALES
lid be lental kad c ic av	To Be	GEORGE D. WHITCOE				VIRGINI	A DORIS P	ULLEN	
2 should be filed within and Mental Hygiene. Ia markad other than aumatic avant, the Mental to a second to the Mental to a second to the Mental to a second to the Mental to a second to the Mental to a second to the Mental to a second to the Mental to a second to the Mental to a second to the Mental to a second to the Mental to the Menta	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Maili	ng Address (Street a		al Route Number, C		e, Zip Code)
1 and 2 Health a tem 27 lg		CYNTHIA WRAY (SIS	TER)	406 I	OX DEN LI	N., MILLE	RSVILLE,	MD 21108	3
es 1 and of Health of Hem 27 r other tra		20a. Method of Disposition	1 0	lace of Dispo	sition (Name of natory or other plac	e) I	Date 20	c. Location - City	or Town, State
		1 XBurial 2 ☐ Cremation 3 ☐ 1  Other (Specify,	nemoval nom State		OK CEM.	1	28, 2004	WILMING	GTON, DE
permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	500	22	2. Name and Addres	s of Facility			
207 29		23a. Part1. Enter the disease, or comp	Wish				ISON FUN		
The law requires that the death certificate be executed to the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit or the contract of the c	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b						
eath certificate attending physic for use as the	an/Medical	230. Was decedent pregnant	d. 23c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal		Ectopic pregnancy			23d. Date of c	delivery
trihe deal by the att tached fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown		Other (specify)			Month	Day Year
w requires that been signed to should be det	by	Part II. Other significant conditions co	ntributing to death but not result failure		nderlying cause give	en in Part I.		_ \	to the cause of death? Probably 4 Dunknov
e law re has be je 2 sho	Completed	Coronary ar	tery disease				24a. Was an		autopsy findings availat
The The ate has page	mo;	Ischemic Car	chomy opathe	1_			autopsy performed 1 Yes 2 D	d2 death	
ician: Th certificate ector, pag		25. Was case referred to medical examiner?				26. Place of Death	(Check only one)	(1.10)	
8 5	P <sub></sub>	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatien		4   Nursing Ho	me Kesidenc	e 6 ⊡Other (Sp	овсіfy)
Attending P	ertification;	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1 □ Y	at ∵? ∕es 2 □ No	28d. Describe how	injury occurred	
spital or Attene ours after death eral Director: filled in by the	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,
% d ¬ >	edical (	29a. Certifier (Check only one)  (Check only one)  ∫ Certifying Phy  ∠ Medical Exami	sician: To the best of my knowner: On the basis of examination and manner stated.	wiedge, death ion and/or inv	occurred at the tim restigation, in my op	e, date and place, a pinion, death occurr	and due to the caus ed at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
To the P within 24 To the F complete	-	29b. Signature and title of certifier	0		29c. License	number MCery	19nc/ 29d.	Date signed (Mo	nth, Day, Year)
	1	1 de la com	teleone MD					8/26/0	n 4
F ≥ 5 8		107/217/1/1/101	Yekloro IVIL		000	25675		0 /26/6	7
		30. Name and address of person who co		23a) (Type		33675		0 /26/0	
8 35.8		30. Name and address of person who co			Print)		ElFton, M		

			1 _ State		partment of Health and ertificate of Death			
			Registrar  1. Decedent's Name (First, Middle, Last)		crimeate of Death	2. Date of Death	g. No. 2	9Time of Death
	Physici		-			Month	Day Year	1031 AM
	/Medi Examir		Betty Lee Weems  4a. Fecility Name (If not institution, give st.	reet and number)	4b. City, Town, or Location of Deat		4c. County of Deeth	
	Zami		2701 St. Leonard H	load	Port Republic		Calvert	
	Funeral Director		5. Social Security Number 6. Sex 212–28–9566	7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day,	Year) 9. Birth	pplace (State or Foreign intry) yland
	p ,		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town o	Landing			10d Jailda Cib. Limita
	arylan ahow	2						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	ecto	MD Calvert  10e. Street and Number	Port Re	epublic 10f. Zip Code	10	lg. Citizen of What Cou	
	with t	ā	2701 St. Leonard Ro	and a		10		antry r
	leath	era			20676  3. Was Decedent of Hispanic Origin? (S	ipecify Yes or No-	USA 14. Race - Amer	ican Indian,
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show he Medical Evancine must be notified at	by Funeral Director	1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 № No Specify:	to Rican, etc.)	Black, White Specify:	ite
ğ	72 hours natural',	ted	15. Decedent's Educa		cedent's Usual Occupation	tion 1	6b. Kind of Business/li	
2	d within 72 ho jiene. r than "natur the Wedital	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	ive kind of work done during most of wo a. DO NOT use retired)	rking		
7		Con	12	Sec	eretary		Real Estat	te /Law
nd	2 should be filed withir and Mental Hygiene. is marked other than sumatic avant, the Me	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, M	laiden Sumame)	
χ	should nd Men marke	2	John Prout		Dorotl			
Maryland	s 1 and 2 should be filed t Health and Mental Hyg Itam 27 is marked othe other traumatic avant,		19a. Informant's Name/Relationship (Type		ailing Address (Street and Number or R			
	s 1 and 2 of Health Itam 27 i		Robert D. Weems ( 20a. Method of Disposition	20b. Place of Di	11 St. Leonard Road		Oc. Location - City or T	
٥	00==		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	compton (	rematory or other place)			
Baltimore,	permit. Pag Department Importent: I any injury o		*4 □Donation 5 □ Other (Specify)	Lee C	ematory Aug 22. Name and Address of FacilityLed		Clinton h	
Ba	permit. Departm Importar any inju		Mehand W. Le		8 125 Southern Mary			
			23a. Part 1. Enter the disease, or complic	ations that caused the death. Do not				Approximate
	Physician	2	shock, or heart failure. List only one immediate Cause (Final	cause on each line.	14	1	14	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	Voutria	var ur	very wine	۵.
Н	Examiner							
M		Der	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Examine	that initiated events c.					
00	e exe sian a urial-		resulting in death) Last	Due to (or as a consequence of):				
8760	cate be ex ohysician the buria	llca	d.					
9	n certific anding p use as	Physician/Medical	IF FEMALE:	c. If yes, outcome of pregnancy				
Вох	eath certif attending for use as	lan	in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delik Month	very Day Year
o.	that the de ed by the detached	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	J Other (specify)			
٩	that the		Part II. Other significant conditions conti	ributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Vital Records,	uires tha signed I	Completed by	advanced A/	Theimer &	ilateral break	1 ☐ Yes	s 2₽No 3□Pro	bably 4 Unknown
00	w requir	lete	Co ads	ranced arts	28.22	24a. Was an	24b. Were aut	opsy findings available
Re	The lav	m C	Currey wi	rac-as war	1.17.2	autopsy perform	ed? prior to co	ompletion of cause of
ta	10		25. Was case referred to medical		26 Place of De	1 Yes 2	☑ No 1 ☐ Yes	2 No
>	ding Physician: h. After this certifications and director,	To Be	examiner?	spital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Othor		nce 6 Other (Spec	(fv)
of			27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Tim	e of 28c. Injury at	28d. Describe how		.,,,
io	Attending F r death. ector: After by the funer	atlo	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Say Your)	M 1 ☐Yes 2 ☐No			
Division	in Signature	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (	29a. Certifier 12 Certifying Physic (Check only one) 2 Madicel Examina	cian: To the best of my knowledge, d ar: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To th withir To th comp	Z e	29b. Signature and title of certifier	10.00	29c. License number	29	d. Date signed (Month,	Day, Year)
•			) para	to food	139522		8/23/0	7
			30. Name and address of person who con	pleted cause of death (Item 23a) (Ty	pe, Print)		0	7
	10		110 Hospital K	d. Fr. Fredo	rich MA	2067	トコ	. Tears
	St. Regist	ate	31. Date filed (Month, Day, Year)	32. Registras Signature	& Specks			

**Physician** /Medica **Examine** 

**Funeral** Director 1-

ASZ	Plea	se Type or	Print in Black In	delible	e Ink.	Ensu	ıre A	II Conies A	re I edi	ible	
For State			of Maryland / Depa	artmer	it of H	ealth a	and N	-	_	Dic.	
Registrar	ne (First, Midd	le, Last)	Ce	rtificat	e or t	Jeain		2. Date of Death		04	3, Time of Death
	WILI	IAM EUG	ENE YUHASZ	III				Month AUGUST	Day 1.7	Year 2004	5.47a M
Facility Name	(If not institutio	n, give street and nu	ımbər)	4b. City,	Town, or	Location	of Death		4c. County	of Death	
OPES C	REEK RO	AD		FAUL	KNER				CHARL	ES	
ocial Security 90-84-		6. Sex M∏M 2□F	7. Age (In yrs. last birthday) 20 Yrs.	If Unde Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, ) JAN. 12,	<sup>(ear)</sup> 1984	Соц	olace (State or Foreign ntry) ORIDA
al Residence	of Decedent										
State	10b. County	1	10c. City, Town or Lo	ocation							10d. Inside City Limits
FL.		MOLIN	Ю						1 XYes 2 □ No		

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Marical Examinar must be notified at once. B

Baltimore, Maryland 21215-0036

Pnysician /Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 941

Division of Vital Records, P.O. Box 68760,

er	4a. Facility Name (If not instit	ution, give s	treet and nu	ımber)		4b. City,	Town, or	Location	of Death	A ALUCALIA	4	c. County	of Deat	h
	POPES CREEK B	ROAD				FAUL	KNER					CHARL	ES	
	5. Social Security Number 590-84-4977	6. Sex	M 2□F	7. Age (In yrs. 20	last birthday) Yrs.	If Under Months		If Unde Hours	Min.	8. Date of (Month,	Day, Yea	r) 1984	Co	hplace (State or For buntry) LORIDA
	Usual Residence of Deceden			10- 04										
_	10a. State 10b. Con	•		Tuc. Cit	ty, Town or Lo									10d. Inside City Lin
cto		CAMBIA	<u> </u>		-	MOLIN	0				1			1 [X]Yes 2 [
Olre	10e. Street and Number					10f. Zip	Code				10g. 0	Citizen of	What Co	ountry?
rai	7031 CHEST							577					J.S.	
une	11. Marital Status		Armed F		.S. 13.	Was Deced If Yes, spec	lent of Hi cify Cuba	ispanic O n, Mexica	rigin? (Sp an, Puerto	ecify Yes or Rican, etc.)	No-		ce - Ame ck, White	rican Indian, e, etc.
Be Completed by Funeral Director	1 Never Married 2 3 Widowed 4 Divo		1 XYes If Yes, Gi Year or E	ive DatesACTIV	UTY E	1 🗆 Yes	s XNO	Specify	<i>/</i> :			Specif	W	HITE
ete	15. Dece (Specify only hi	dent's Educ ghest grade	ation completed)		(Give	dent's Usua kind of wo	rk done a	luring mo	st of work	king	16b.	Kind of B	usiness/	Industry
mpl	Elementary/Secondary (0-1	2)	College (	1-4or 5+)	life.	DO NOT u	se retired,	)						
S						U.S.	MAR			457			DEFE	NSE
	17. Father's Name (First, Mid	die, Last)						18. Moti	ner's Nam	e (First, Mid	dle, Maide	en Suman	ne)	
_C	WILLIA		YUH	ASZ JR						USSAN		SMIT		
	19a. Informant's Name/Relat			/= . = . = .		int.				ral Route Nu				Zip Code)
	WILLIAM E.	YUHAS	SZ JR.					T RD		OLINO,	_			
	20a. Method of Disposition 1 X Burial 2 ☐ Cremat	ion 3 ⊟R	emoval from		Place of Dispo cemetery, crea	matory or o	ne of ther place	9)		Date	20¢.	Location -	- City or	Town, State
	`4 □Donation 5 □ Othe				MORGAN					-2004		OLINC		
	21. Signature of Funeral Sen	vice Ligense	rbux	MO0	091 C	2. Name an HAMBE 801 C	d Addres RS F LEVE	s of Faci UNER LAND	AL HO	OME & , RIV	CREMA ERDAI	ATORI	UM, I	P.A. 20737
ıer	23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	e, or complie List only on a	Due to	caused the deat each line. (or as a cursed (or as a conseq	MES uence of):	ter the mod	e of dying	g, such a	s cardiac	or respirator	y arrest,			Approximate Interval Between Onset and Death
ical Exami	cause. Enter Underlying Cause (Closace or Injuly) that initiated events resulting in death) Last		Due to	(or as a conseq	uence of):									
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2:	1 Live	itcome of pregna birth 2 Feta nant at time of d	Ideath 3[	□Ectopic pr □ Other (sp					-	23d. Da Mo	te of deli	very Day Year
	Part II. Other significant con	ditions con	tributing to c	death but not res	ulting in the u	inderlying c	ause give	en in Part	I.		id tobacco		ribute to	the cause of death?
Completed by										24a. W au pe 12 Ye	itopsy irformed?		prior to d death?	topsy findings availa completion of cause 2 \( \sum \) No
Be	25. Was case referred to me examiner?	-	ospital:				Otho			h (Check on				
10	1 X Yes 2 No		1 1 1		ER/Outpatier				lursing Ho	ome 5 R				ify) SCENE
satlon;	25010010011	estigation	28a. Date (Mor	nth, Day Year)	28b. Time of Injury	A M	8c. Injury Work 1 🗆 Y	at :? /es 2 2	<b>3</b> No	divie	00	mak	er u	and the same of th
Certification;	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide de	termined	28 Place build	e of Injury - At he ling, etc. (Specif	ome, farm, str y) Yoa d		, office			28f. Location City or Popes Ci	Town, Sta	te)	er or Ru	ral Route Number,

State

Tashu Z Greer 31. Date filed (Month, Day, Year) AUG 23 2004

29b. Signature and title of certifier

29a. Certifier

Medical

111 Penn Street, Baltimore, Maryland 21201 Greenberg 32. Degistrar's Signature souls

completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

**OCME** 

29d. Date signed (Month, Day, Year)

AUGUST

17, 2004

Registrar

			Plea	se Type or Pri					•		-	
			For State Registrar	State of Ma	arylan	-	artment of F		•	giene Reg. NG		20772
	*	4 .	1. Decedent's Name (First, Middle	, Last)					2. Date of Dea	ath		3. Time of Death
	Physici /Medic		LULA G.	ALLEN					Septemi	Day	y Year 4 200	4 9:00 AM
)	Examin		4a. Facility Name (If not institution	_				r Location of Deat	1	4c.	County of Dea	ith
3		2			tim	~ _	Baltimo		·		N/A	
	Funeral		5. Social Security Number	6. Sex 7. Ag	. ,	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year)	C	thplace (State or Foreign ountry)
١,	Director		173-24-7331 Usual Residence of Decedent		78	3			SEPT 15	19:	25 JSOU	TH CAROLINA
	yland		10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
	Ba-fas	ctor	MARYLAND N/	A	E	BALTIM	ORE					1 XYes 2 No
	death with the Maryland ms 23a or 28a-1 ahow rmust be n-tiffed at	Director	10e. Street and Number				10f, Zip Code			10g. Cit	izen of What C	ountry?
	ath w		3018 ROCKWOOD				212				.S.A.	
	er de Itams	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		<ol> <li>Race - Ame Black, White</li> </ol>	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☒ Divorced	ed 1 ☐ Yes 2\\ If Yes, Give Year or Dates:	NO		1 ☐ Yes 2 🛣 No	Specify:			Specify: BT.	ACK
Š	2 hou	ted	15. Decedent	's Education		16a. Dece	dent's Usual Occup	ation		16b. Ki	ind of Business	
21215-003	filed within 72 hours after Hygiene. ther than "natural", or Ita ant, the Medical Examine	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work done of DO NOT use retired	during most of wor d)	king			
	filed wi Hygien other th		llth grade	(1-2)		HOUS	EWIFE				HOME C	ARE
Maryland	ba id o	Be	17. Father's Name (First, Middle,						ne (First, Middle,		Sumame)	
ج	d 2 should ba th and Mental 7 is markad c traumatic eve	To	CHARLIE GAMB: 19a. Informant's Name/Relationsl			19b Mailir	ng Address (Street		COPELAN		y Tours State	Zin Code)
<u>8</u>	12: har 7 ia		Joyce B. Allen				Rockwood			-		
ē,	- T 0 =		20a. Method of Disposition	7	20b. Pl	ace of Dispo	sition (Name of natory or other place		Date		ocation - City or	
altimore,	Pagas nent of int: If it iry or o		1 A Burial 2 □ Cremation  1 4 □ Donation 5 □ Other (S)				CEMETERY	1	9-04	LAN	DSDOWNE	, MARYLAND
a	permit. Pagas Department of I Important: If it any injury or o	H	21. Signature			22	. Name and Addres					
n	207 29		100	Collew		1	206 W NOF	TH AVENU	E			FILL I . A.
	. ,		23a. Part f. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	I the death ne.	. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- a Hemor	ma	7	cepo	voscu	ar acc	100	nt	20045
	Examiner			Due to (or as	a consequ	ieuce ot):						55
		ner	Sequentially list conditions, it any, leading to limit additionable cause. Enter Underlying	b. Juan for as	a: nonsequ	ience of/						Jugar C
	acuted ind transii	amin	Cause (Disease or injury that initiated events resulting in death) Last	с								
Ď,	The law requires that the death certificate be executed to has bean signad by the attending physician and bage 2 should be detached for use as the burial-transit	E	resulting in death) cast	Due to (or as	a consequ	ence of):						
68/60,	physics the	Physician/Medical		d								
ВОХ	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						2	23d. Date of de	livery
-	death e atte	icial	in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Live birth 4□Pregnant at			Ectopic pregnancy Other (specify)				Month	Day Year
J.	at the de by the a stached t	hys	9 🗆 Unknown	9□ Unknown								
	w requires that baan signad b should be deta	by	Atnal Fibrica		ut not resu	Ilting in the ur	nderlying cause give	en in Part I.				the cause of death?
ecords,	requi	eted	MICION COMIC	21 (01.)							ZINO JUPI	robably 4 Unknown
Hec	has by	Completed							24a. Was a autop: perfor	sy	24b. Were at prior to death?	utopsy findings available completion of cause of
Vital		e Co	25. Was case referred to medical						1 ☐ Yes	202 No		2 No
	ysicia is cert direct	0 8	examiner?	Hospital: 1 Inpatie	nt 2∏1	ER/Outpatien	t 30000 Othe	26. Place of Dea er: 4 □ Nursing H	th Check onl or		COthor (Con	offs)
OI	g Phy er thi		27. Manner of Death	28a. Date of Inju		28b. Time of Injury		at	28d. Describe h			City)
Š	uttanding F death. ctor: Aftèr y the funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig	ation	, roan,	inquity		Yes 2 No				
DIVISION		Certification:	3 Suicide 6 Could r 4 Homicide determ		ury - At ho	me, farm, str	eet, factory, office		28f. Location (S City or Town			ural Route Number,
_	Hospital of the hours a Funeral C		29a. Certifier 15 Certifyin	g Physician, T. the best		ulandan dan th						
	To the Hospital or within 24 hours after To the Funeral Diracomplately filled in b	edical	(Check only 2 Medical !	g Physician: To the best Examiner: On the basis of and manner sta	examinat	ion and/or inv	estigation, in my of	pinion, death occu	red at the time, d	ause(s) late and	place, and due	s stated. to the cause(s)
	To the within 2 To the complat	Me	29b. Signature and title of certifier				29c. License	number	2	9d. Date	e signed (Mont	h, Day, Year)
			Onn m	acientino	DC	)	Re	5-000	) (	Sep'	tonbe	14,2004
	5		30. Name and address of person	who completed cause of d	eath (Item	23а) (Туре,	Print)					
	)		Ann MacInty	2004 S	1001	1705	piral of	-ROTTIN	rore			
	Sta Registr		31. Date filed (Month, Day, Year)	2004	ar s signat	K do	oute					
	1.8		255 10	EUUT CONT		1						

DHMH T/ HeV 1/2001

			State of Maryland / Department of Heal  1- State Registrar  State of Maryland / Department of Deal  Certificate of Deal	th and Mental Hy	•
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Florette A. Bush	2. Date of Do Month Sept.	Day Year 5.150
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Loca  Stella Maris Hospice  Tows	ation of Death	4c. County of Death Baltimore
	Funeral Director			ours Min. 8. Date of Bi	9. Birthplace (State or Foreign Country) Wisconsin
	Maryland a-f ahow	tor	10a. State 10b. County 10c. City, Town or Location MD Baltimore Middle River		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 7250 Gassinger Road 21220	1	10g. Citizen of What Country? USA
980	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f ahow any injury or other traumatic avant, ite Medical Evariation than the facilities at anote.	by Fune	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 4 □ Divorced  1 □ Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No Specify Cuban, Me  1 □ Yes 2 ☒ No Specify Cuban of Specify Cuban, Me  1 □ Yes 2 ☒ No Specify Cuban of Specify Cuban o		o- 14. Race - American Indian, Black, White, etc.  SpecifyWhite
Maryland 21215-0036	d within 72 ho piene. r than "natu It e Medical	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th  15a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use relired) Homemaker	n most of working	16b. Kind of Business/Industry  own home
yland 2	12 should be filed within hand Mental Hygiene. 7 Is marked othar than "I traumatic avant, II = Med	To Be C	17. Father's Name (First, Middle, Last)  Paul Baumgarder Sr.	Mother's Name (First, Middle Juilette I	Dohl
	and 2 she salth and n 27 Is m ar traum		19a. Informant's Name/Relationship (Type, Print)  Carol Stoecker / daughter  19b. Mailing Address (Street and Ni 7250 Gassinge		
Baltimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)		20c. Location - City or Town, State  Baltimore MD
Balt	permit. Departimont any inj		1. Lerry Connelly 300 Mace	Ave. Balti	FuneralHomeofEssex more MD 21221
760, 小	Physician /Medical Examiner and physician and physician and the prujet ransit the private ransit and the private ransit r	dical Examiner	23a. P. 11. Enter the disease, shock, or heart failure. Tist only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  CHRONIC OBSTRUCTED PULMONARY  Due to (or as a consequence of):  b		arrest, Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certilica ate has been signed by the attending ph page 2 should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown		23d. Date of delivery Month Day Year
<u>α</u>	w requires that in been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F		tobacco use contribute to the cause of death?  Yes 2 □ No 3 □ Probably 4 元Unknown
Il Records,	The lav ate has page 2	Completed		24a. Was auto perfe 1 □ Yes	
Division of Vital	Attanding Physician: The lav r death. actor: Atter this certificate has by the tuneral director, page 2	Medical Certification; To Be	examiner?  1	28d. Describe 2 \sum No	idence 6 Cother (Specify) HOSPICE how injury occurred  (Street and Number or Rural Route Number,
Ō	To the Hospital or Attand within 24 hours after death To the Funaral Director: completely tilled in by the	sai Cert	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dat	ite and place, and due to the	cause(s) and manner as stated.
	To the Ho within 24 To the Fu	Medic	(Check case) Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.  29b. Signature and title of certifier  29c. License num	, deali occurred at the time,	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	725	9/8/04
	10		DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TI	MONIUM, MD 21	1093
	Sta Registi	4.3	31. Date filed (Month, Day, Year)  SEP 1 0 2004  32. Registrar's Signature  Apack	,	

SEPTEMBER 8, 2004 5:15 a.m.

FLORETTE BUSH

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ELIZABETH BIETSCH BRIZENDINE September 2004 5:40 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Blakehurst If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug. 10, 1917 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 💢 F Months 87 Yrs. 204-03-6265 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad othar than "natural", or Itams 23a or 28a-f show other traumatic evant, the Modical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 W. Joppa Road 21204 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other then "netural", or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ years Nurse Educator Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Oscar Bietsch Grace Walk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Austin W.Brizendine (son) 411 Rockfleet Road #302 Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Pagé Department d Important: If any injury or once. 9-9-04 \* 4 □ Donation 5 □ Other (Specify) Green Mount Crematory Baltimore, Maryland Mitchell-Wiedefeld Funeral Home, Inc 6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licensee Inc. Fen 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** melastate /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown s been signed by the should be detached Part II AOther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been prodism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital of or Attanding Physician: after death. Director: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Corsmil BAUTIMORE mo 21294 6701 IN CHARLET 31. Date filed (Month, Day, Year) egistrar's Signature State Registra

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 11:00P M Bender \$eptember 08 2004 Betty /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Mariner Health of Glen Burnie Glen Burnie Ann Arundel If Under 1 Year If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 21 F Yrs. Director 234-44-2562 Oct. 23 1923 West Virginia 80 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or iteme 23a or 28a-f show treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1422 Bonsal Street 21224 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed withIn 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: White ð 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Tin Sorter NABethlehem Steel permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked oth any injury or other treumatic event 20x8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Averal Morrison Onie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1422 Bonsal Street Baltimore, Maryland 21224 <u>August v. Bender ( Husband )</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State September 13 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill ,2004 Baltimore, Maryland 21. Signature of Foneral Service Licensee 22. Name and Address of Facility
W. Dabrowski/Chojnacki Funeral Homes P.A. 1005 Dundalk Ave. Baltimore, Maryland 21224 23a. Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1 HOUR /Medical Due to (or as a consequence of): Examiner 104640 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ned by the atter a detached for u in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown signed by 1 d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 1 Yes 2 No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? VASCULAR DISEASE this certificate PERIVITERAL 2 XNo 1 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1x Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7 H.D Kerl 0-22609 September 10, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rubin Reider M.D. 7445 Furnance Branch Road Glen Burnie, Maryland 21060 R. Registrar's Signature 31. Date filed (Month, Day, Year) State SFP 1 0 2004 Registrar

			For State Registrar	State of Maryla	-	artment of H		-		00777
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	Examir		4a. Facility Name (If not institution		-	4b. City, Town, o	r Location of Death		4c. County of De	
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	death w	Funeral	11. Marital Status	12. Was Decedent Ever in I	U.S. 13.	Was Decedent of H	1 -	pecify Yes or No		erican Indian,
36	ours after el', or Ite Examiner	by Fu	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 ☐ No If Yes, Give		1 □ Yes 2 □ 1√0	Specify:	, , , , , , , ,	Specify:	( *
21215-0036	n 72 hours after death with the Maryland "neturel", or Items 23e or 28e-f show patical Examiner must be notified at		15. Decedent	Year or Dates:	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busines	Uh (( C
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Je,			20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other place	(9)	Date	20c. Location - City o	r Town, State
<u>m</u>			1 ☐ Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (Sp	3 □Removal from State pecify)	-	Cemete	1 (1)	104	Bo Ho. MC	)
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			shock, or heart failure. List of	complications that caused the dea only one cause on each line.	1	D		or respiratory a	rrest,	Approximate Interval Between Onset and Death
A. A.	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	ratin	near	nohia			
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Вох	eath certific attending p I for use as	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		Ectopic pregnancy			23d. Date of de	elivery
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of V	di S	To B	examiner? 1 \( \sum \text{ Yes}  2 \sum \text{ No} \)		☐ ER/Outpatier	See all the second sections	4   Nursing no	ome 5 ☐ Resid	dence 6 Other (Spe	ecify)
no	ing Vfter une	inol :	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		28b. Time or Injury	Worl		28d. Describe I	how injury occurred	
Division	Attending r death. sctor: After by the funer	Certification;	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot bo	nome farm str		Yes 2 □ No	28f Location (	Street and Number or F	ura I Route Number
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	ne Hospitel or Attend n 24 hours after death ne Funerel Director: A	sal C	29a. Certifier 1 Certifying	g Physicien: To the best of my kn	owledge, deati	occurred at the tin	ne, date and place,	and due to the	cause(s) and manner a	s stated.
	To the Hos within 24 h To the Fur completely	ledical	one)	Exeminer: On the basis of examin and manner stated.	ation and/or in					```
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	Ó		30. Name/and address of person to	NNO completed cause of death (Ite	m 23a) (Type, +++7, i	= Main	St L	restric	ster Mi	1 21157.
*-	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 0 21	32 Registrar's Sign		Spale	/		nter Mi	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** Arthur Theodore Berilla, Jr. SEPTEMBER 3, 2004 /Medical 5:05P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 11800 TWIN LAKES DRIVE PRINCE GEORGES BELTSVILLE 5. Social Security Number 6. Sex 1 → M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 196-36-1154 Yrs. Director 57 1946 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 XNo Directo Maryland Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11800 Twinlakes Dr. Apt. 302 20705 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ሺ Yes 2 □ No If Yes, Give Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ite 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement Fed. Government(FBI) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur T. Berilla, Sr. Catherine Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2906 Glenmore Ave., Apt. D. Pittsburgh, PA 15216 Jane C. Berilla (Sister) other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State ō permit. Page Department of Important: If any injury or once. 9/13/04 Mt. Lebanon, PA Mt. Lebanon ^ 4 □ Donation 5 □ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility Beinhauer & Son Company 2630 W. Liberty Ave., Pittsburgh, PA -UMMer 15216 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician a atherosclerone /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to (or as a nonsequence of) Examiner burial-transit Due to (or as a consequence of): nding physician use as the buria Box 68760. Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I detached à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cartificate has autopsy performed? death? Yes 2 🗌 No 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death C eck onl one examiner' Other: 4 Nursing Home 5 Residence 6 XOther (Specify) SCENE 1 Tyres 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA this fillad in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funaral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER 4, 2004 O.C.M.E. all 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Baby Girl,	A ·	Bar	ve	,		2	Date of Death Month	Day	Year OO4	3. Time of Death	1
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	ne Maryland 8e-f show	Director	Usual Residence of Decedent  10a. State  10b. County  MD  Prince G		ty, Town or Lo	aure1					4,		0d. Inside City Limits	
99	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural; or items 23e or 28e-f show other traumatic svent, the Medical Eventher must be notified at	Funerai	10e. Street and Number 8741 Contee Road  11. Marital Status 1 ☒ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1	ı	Vas Decede	ent of His fy Cuban	2070 panic Origi , Mexican,		fy Yes or No- can, etc.)		A - America - White, e	an Indian, etc.	
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<u>α</u>	w requires that been signed b should be deta	by	Part II. Dther significant conditions con	tributing to death but not res	ulting in the ur	iderlying cai	use giver	in Part I.			_		cause of death?	1
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)	rs⊢ŏ		30. Name and ddress of person who con	HalaA mpleted cause of deat (item	n 23a) (Tvoe. I	Print)	56	557	1	1	travst	2.	2004	
N	Sta Registr		Cynthin J. Holcro 31 Date filed (Month, Day, Year) SFP 1 0 2004	32. Registrar's Signa	49 ture	fo El	aste	en 4	wend	ve, Ba	1 frmor	e, K	ay, Year) 2004 [1],21224	_

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Sept. 7, 2004 **Physician** Yeer Edward Cromwell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Riverview Nursing Center Essex 7. Age (In yrs. last birthday) 8. Date of Birth February 919 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min NOW 20 F 85 Ohio Yrs. 215-12-4465 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits r then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Essex Baltimore MD 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 812 MArtin Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status nit. Pages 1 and 2 should be tiled within 72 hours after narmen of Health and Mental Hygiene. ortant: If item 27 is marked other then "natural; or ite injury or other traumatic event, the Medical Example. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Yes. Give If Yes, Give Year or Dates: þ SpecifyIhite 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Auto 4th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Cromwell unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 812 Martin Road Baltimore MD 21221 Emma Cromwell /wife 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other p Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 9/9/04 Baltimore MD BayviewCrematory `4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee on 300 Mace Ave. Baltimore MD 23a. Parti. Enter the disease, or completions that caused the death. Ponot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Corney Vorcela Disease Hyperterning Arterinschulig Physician years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner equires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ostractice Diornay Beach 1 Yes 2 No 3 Probably 4 ∃Unknown peed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No elecario 24a. Was an page 2 s autopsy performed' certificate Jeneuer ha 1 Yes 2 410 To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this cartifics completely filled in by the funeral director, t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 27. Manneg of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Critifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Willowe D19667 09-08-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7310 Ritcher Higherry + 508 Chen Borice, The land 21061 wireaz Las Williage 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			For State Registrar		State	of Mary			tment ificate				lental Hy	giene Reg. No	a other on t		2878	***************************************
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	/Medic	al	Margaret L. Conne		)		4b. City, Town, or	r Location of Do		er 4 200	14 nty of Death	17:30p	M
	Examin	er	7156 Greenwood Avenue	·	,		Baltimore		alli				
	Funeral		5. Social Security Number 6. S	Sex 7. Ag	ge (In yrs. la:	st birthday)	If Under 1 Year Months Days	If Under 24 h	Irs. 8. Date of Bir in. (Month, Da	th v Year)	timore 9. Birth	place (State or intry)	Foreign
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	land ow		Usual Residence of Decedent  10a. State  10b. County		10c. City,	Town or Lo	cation					10d. Inside City	Limits
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	or 28s	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	of What Cou	intry?	-23
	ath wi	ral	7156 Greenwood Avenue				21206			USA			
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920	hours after death with the Maryland tural; or Items 23a or 28a-f show a Examinar must be notified at	by	3 √Widowed 4 □ Divorced	If Yes, Give Year or Dates:	(10		1 ☐ Yes 2 🗓 No	Specify:		Spec	city: W	iite	
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lan	9 E 2 9	To Be	James W. Hayes					Vallie	Lee Platt				
Maryland 21215-0036	and and sm		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address (Street	and Number or	Rural Route Numbe	er, City or Tow	vn, State, Zi	p Code)	
	1 and 2 Health tam 27 l		Donna Shiloh		ant Di-		Lamar Court		ston, maryla				
Baltimore,			20a. Method of Disposition  1 Deurial 2 Cremation 3		, !		sition (Name of natory or other place		Date	20c. Location			
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x 68	death certificat e attending phy id for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome									
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	7		30. Name and address of person who MIN CME				Print) per Cir	de #	211, Bo	Utime	sefin	10212	236
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Physici /Medi		1. Decedent's Name (First, Middle, La Floyd Richard	st) Ison Conn	ell						2. Date of E Month Sept.		<sup>Day</sup> 2004	Year	3. Time of Death 6:41AM M
Examir		4a. Facility Name (If not institution, given Dulaney - Towson F	lealth Car	e Cen		Tows	on	Location o				4c. County Balti	more	
Funeral Director		5. Social Security Number 436-40-0239  Usuel Residence of Decedent	ex 7. Ac	74	last birthday) Yrs.	If Under Months	Days	If Under: Hours	Min.	8. Date of E (Month, I July	7,19	930	9. Birthr Cour LOU1	place (State or Foreign atry) S1ana
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urs after death	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 X Yes 2 ☐ If Yes, Give Year or Dates:	?	I		ent of Hi		gin? (Spe i, Puerto f	city Yes or I	No-		k, White,	
Deficiency interpretation Z.I.Z.13-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "netural", or Items 23a or 28a-f show importent: If item 27 is marked other than "netural", or Items 25a or 28a-f show with jointy or other treumatic avent, the Medical Example instilled at 2016.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		5+)	(Give	dent's Usual kind of word DO NOT use Truck	k done d e retired,	turing most )	t of workin	ng		. Kind of Bu		dustry
uld be filed Aental Hyg rked other	To Be C	17. Father's Name (First, Middle, Last, William Connell	)					18. Mothe		(First, Midd Palme		den Surnam	e)	
and 2 should eath and Men n 27 is marke		19a. Informant's Name/Relationship ( Delia Robinson-			2651	Mile	s A		Bal	Route Num	e, I	Maryla	and 2	21211
mit. Pages 1 partment of He portent: If iten y Injury or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif	y)	Gar	Place of Dispo cemetery, crer	natory or oth Fores	her place t Ve	et. 9	/9/04		Ow	Location - ings	Mills	, Maryland
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Physician /Medical Examiner	ner	23a. Pert1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as	ine. UAR s a conseq	y A	RTE					arrest,			Approximate Interval Between Onset and Death
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To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the t	O	3 Suicide 6 Could not be determined	building, e	tc. (Specif	(y) 					City or T	own, St	ate)		l Route Number,
e Hosp 24 hou se Fune detely fil	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa.	nysician: To the bes miner: On the basis and manner s	of examina	wledge, deat tion and/or in	h occurred a vestigation,	in my op	ne, date an pinion, dea	d place, a th occurre	ind due to the	e, date a	e(s) and ma and place, a	nner as si ind due to	ated. the cause(s)
To th withir To th	Me	29b. Signature and title of certifier						number				Date signed		
		30. Name and address of person who	completed cause of	death (Item	n 23a) (Tvne		UU:	5 410 2.600	97.1	RSRT	7	- 08	5-2	AVENUE
STIVA		KALU UMA	WESTS108	Me	LDICAL	GROU	P	BALT	rimo	RE	mi	21:	712	ANNS AN
St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 1 0 200	4 Zer Regist	rar's Signa	ature	de la								

Please Type or Print in	Black indelible ink.	Ensure All	Copies A	re Legib
State of Manua	nd / Danamana - 411	a = 111 1 6 4 -		

M.	.DUBOSE 4-299		1 - For State Registrar	State of M	laryland / Depa	artment o		nd Mental Hygi	-	29701						
	Physic	jan	1. Decedent's Name (First, Middle, Las	1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death												
	/Medi		CARL MICHAEL					Septembe	/							
	Exami	ner	4a. Facility Name (If not institution, give		Death	4c. County of De										
			Sinai Hosp  5. Social Security Number 6. Sc		Baltimos Year   If Under 2		N/A									
	Funeral Director		218-37-3722	9X 7. A	ge (In yrs. last birthday) 24 Yrs.	If Under 1 \ Months D	Days Hours	Min. (Month, Day, )		rthplace (State or Foreign country)						
	P .		Usual Residence of Decedent		MARCH I	MARCH 1 1980 MARYLAND										
	arylar show	_	10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Ins							
	Be-f	ecto	MARYLAND N/A	IMORE				1 ☑ Yes 2 ☐ No								
	with (	by Funeral Director	10e. Street and Number			10f. Zip Co		100	g. Citizen of What C	ountry?						
	eath w	eral	4100 DUDLEY AVE	NUE 12. Was Deceden	t Ever in U.S. 13.		21213	-2/0	U.S.A.							
(0	ifter dea r Items niner m	F	Married 2 Married	Armed Forces	?	If Yes, specify	Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Black, Wh							
036	72 hours after death with the Maryland neture!', or Items 23e or 28e-f show Jisal Examinar must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	ļ	1 ☐ Yes 2 🔀	No Specify:		Specify: BL	ACK						
215-0036	72 hc	Completed	15. Decedent's Ed	15. Decedent's Education (Specify only highest grade completed)				of working	16b. Kind of Business/Industry							
121	within lene. then "	ldm	Elementary/Secondary (0-12)	College (1-4or	1-4or 5+) life. DO NOT use retired)			n Working								
121	filed withi Hygiene. other then		12th grade ALARM TECH  17. Father's Name (First, Middle, Last)  18. Mother's						ADT							
and	outd be f Mental H arked of atic eve	Be C						s Name (First, Middle, Ma	iden Sumame)							
Maryland	2 should I and Men Is marker	2	CLARENCE DUBOSE  19a. Informant's Name/Relationship (7		19h Mailir	a Address (S		RICE JONES	RICE JONES  Rural Route Number, City or Town, State, Zip Co							
Z	C1 (G 0) (G		Clarice Jones-And	,												
ē,	es 1 and 2 of Health fitem 27   r other tre		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	of !	Baltimore, Date 20	Mary Land c. Location - City or							
Ë	o = T o		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		DRUID RII	•	1	9-15-04 B7	ALTIMORE,	MADALAND						
Baltimore,	permit. Page Department o Importent: If eny injury or once.		21. Signature of 5 meral Service Ligary						LLIIMORE,	MARYLAND						
<u>m</u>	8978		22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.  1206 W NORTH AVENUE													
Ш			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause one cause on each I	d the death. Do not ente	er the mode of	f dying, such as ca	rdiac or respiratory arrest		Approximate Interval Between						
	death certificate be executed  Example a stending physician and extending physician and of for use as the burial-transit		Immediate Cause (Final disease or condition TIPLE FUNCHOT MONA)													
			resulting in death)													
Į,		io io	Sequentially list conditions, if any, leading to immediate	b												
		Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury													
ó		Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):												
8760,	ite be ysicia ne bur	cal														
99	rtifica ng ph as th	Physician/Medical	IF FEMALE:						1							
Вох	leath certific attending pl	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth		Ectopic prean	ancv		23d. Date of delivery Month Day Year							
0.	at the dea by the a stached fo	/sici	1 Yes 2 No	4□Pregnant a 9□ Unknown	t time of death 5	Other (specifi	y)									
٩.	d b b		Part II. Other significant conditions co	o awas in Part I	220 Did tabas	23e. Did tobacco use contribute to the cause of death?										
Vital Records,	uires l signé ld be	d by		or not rosalting in the ar	idenying cause	a diamini Lauri.	1 ☐ Yes	£,								
S	w require been si should b	ete			24a. Was an	-										
Re	The lavate has	ompleted								topsy findings available completion of cause of						
		e Co	25. Was case referred to medical					performed 1 <b>X</b> Yes 2□		2 No						
>	Physicien: this certific ral director,	OB	examiner?	Hospital:	ent 2X ER/Outpatient	30004			ath (Check only one)  Home 5 ☐ Residence 6 ☐ Other (Specify)							
	g Ph ter thi	T. I	27. Manner of Death	28a. Date of Inju		28c. 1	Injury at Work?	28d. Describe how i	injury occurred							
ior	Attending or death.  sctor: After by the funer	atio	1 □Natural 5 □ Pending 2 □ Accident investigation	9/6/00			work? 1 ☐ Yes 2 🗷 No	SVBJECT	was sho	$\tau$						
Division	I or Atter de Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At home, farm, stre c. (Specify)	et, factory, off	City or Lown S	28f. Location (Street and Number or Rural Route Number,								
	urs af			NG- NOT		ALTIMORE, HD										
	To the Hospitel or All within 24 hours after or To the Funerel Direct completely filled in by	edical	(Oriota Drilly ZIX) Medical Exami	mer: On the basis of	t axamination and/or inv	occurred at the	ne time, date and p	lace, and due to the cause occurred at the time, date	o(c) and mannes as	etoted						
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner sta	ated.		ense number									
	Vite		Rano			250. LIC	O.C.M.I		29d. Date signed (Month, E September 07,							
	()		30. Name and address of person who co	moleted cause of												
	ν\		ANA RUBIO	,MD			reet. Ba	ltimore, Mar	vland 212	0.1						
	Sta		31. Date filed (Month, Day, Year)	32. Region	ar's Signature			,	1	.0.1						
. 4	Registr	ar	SEP 10	2004 56	en &	more										

Please Type or Print in Plack Indelible Ink. Engine

		For	State of Marylar	nd / Depa	rtment o	of Health and	Mental Hyg	iene	gible.			
		1. Decedent's Name (First, Middle, Last)	PER PH G835		g. No.	104	29795					
Phys	sician	1. Decodert s Name () "St, Middle, East)	2. Date of Deat Month	Day	Yeer							
<i></i>	dical	4e. Fecility Name (If not institution, give stre	Anthony Philip Dietz							01.39M		
Exa	miner					wn, or Location of Dea	th					
		Atlantic General F	7. Age (In yrs.	last hirthday)	Be If Under 1 \	erlin Year   If Under 24 Hrs	s. 8. Date of Birth					
Fune: Direct		[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]	1 2□F 56	Yrs.	Months D			Year)				
rland ow		10a. State 10b. County	10c. Ci	ity, Town or Loc	ation				10d. Inside			
ith the Marylar or 28a-f ehow	Į.	Maryland Baltim	ore				Dundalk			1 ☐ Yes Ž No		
the r 288	Director	10e. Street and Number	IOI C		10f. Zip Co			Og. Citizen o	of What Coun	itry?		
death with the Maryland ms 23a or 28a-f ehow my 25a or 28a-f ehow	Qie	543 Bayside Drive				21222		Unit	<b>e</b> d Sta	tes		
deat	Funeral	11. Maritat Status 12	. Was Decedent Ever in U	J.S. 13. V	Vas Deceden	t of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or No-	14. R	ace - Americ	an Indian,		
66 after or the	13.	1 ☐ Never Married 2🛱 Married	1 1 Yes 2 □ No		Yes 2		no nican, etc.)			etc.		
-0036 -0036 hours at	d b	3 Widowed 4 Divorced		etnam		лю зреспу.		Spec		te		
1215-0036 within 72 hours after death wann. In amount them 23a.	Completed	15. Decedent's Educat (Specify only highest grade of	tion completed)	(Give I	ent's Usual C	done during most of wo	orking	16b. Kind of	Business/Inc	dustry		
121 121 Vithin ne.	a	Elementary/Secondary (0-12)	Cottege (1-4or 5+)		O NOT use r	retired)						
S/oy O/ laryland 212: 2 should be filed within and Mental Hygiene. Is marked other than	ပိ	17. Father's Name (First, Middle, Last)	2 Years	Sa	les	40 M-4-4- N-	(First Middle 1			tion		
anc ance	Be	Philip P. Dietz					me (First, Middle, A		County of Death  Worcester  9. Birthplace (Stete or Foreign Country) Maryland  10d. Inside City Limits 1 Yes 2 No  ten of What Country?  ited States 4. Race - American Indian, Black, White, etc.  Specify: White Ind of Business/Industry  ansportation  Sumame)  Town, State, Zip Code) land 21222 cation - City or Town, State Indalk, Maryland  dalk, Inc. and 21222 Approximate Interval Between Onset and Death  For Min's  Several YES  3d. Date of delivery Month Day Year  are contribute to the cause of death?  No 3 Probably 4 Dunknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  Other (Specify) occurred  Number or Rural Route Number,  Ind manner as stated.  Signed (Month, Dey, Year)  Several Route Number,  Indicate of Month, Dey, Year)  Several Route Number,  Indicate of Month, Dey, Year)  Several Route Number,  Indicate of Month, Dey, Year)  Several Route Number,  Indicate of Month, Dey, Year)			
arylai should b ind Mentit e	2		O-i-al	405 14-15-	(0		Oma Estep					
re, Maryland 21215-0036  I and 2 should be filed within 72 hours after death with the Maryla Health and Mantal Hygiene 1 the antity of the margin and Mantal Hygiene 1 the margin and Mantal Hygiene 1 the Maryla Maryla for margin and	39	19a. Informant's Name/Relationship (Type Mrs. Pamela L. Di					ural Route Number. undalk, M					
Baltimore, Moemit. Pages 1 and 2 Department of Health Importants if Hear 27 I many injury or other tree.		20a. Method of Disposition	, , , , , , , , , , , , , , , , , , , ,	Place of Dispos								
Baltimore, Department of Hea		12 Burial 2 ☐ Cremation 3 ☐ Ren	noval from State	cemetery, crem	atory or othe	r place)						
altim nit. Pa eartmen ortant:		* 4 □ Donation 5 □ Other (Specify)	Sac	and the contract of		esus Cem.						
Balti permit. Departri Imports	ouce	21. Signature of Fineral Service Licensee	5110	/ B	uda-Ru	ck Funeral	Home of	D <b>u</b> nda.	lk, In	C.		
		23a Part Foter the distance or complica	d 21222									
		shock, or heart failure. List only one cause on each line.										
Physicia /Medic		Immediate Cause (Fixal disease or condition resulting in death)		FEW MINS								
288 Examin		Due to (or as a consequence of):										
35	- in	Sequentially list conditions, if any leading to immediate	SAVA	ERAL YRS								
De la la la la la la la la la la la la la	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec									
2- (14)- 760, Page 18 be executed spician and se burial-transit	xar	that initiated events c resulting in death) Last	Due to (or as a consec	quence ol):								
760, re be expecian	cai											
68 68 ifficate g phy as the	ofbe	d										
	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of pregna					23d L	ate of delive	N/		
Box death cer attendir	<u>S</u>	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		Ectopic pregr Other (specif					•		
S.O. at the de by the grached	hysi	9 Unknown	9 Unknown									
cords, P wrequires that been signed b	by P	Part II. Other significant conditions contri	buting to death but not res	sulting in the un	derlying caus	e given in Part I.	23e. Did tob	acco use co	ntribute to the	e cause of death?		
tal Records, in: The law requires incate has been sign or, page 2 should be							1 🗆 Ye	s 2 🗆 No	founty of Death  Norcester  9. Birthplace (Stete or Foreign Country)  Maryland  10d. Inside City Limits  1			
Record ne law requir	Completed						24a. Was ar	241	24h Wara autoney findings availah			
Rec Re lav he lav age 2	Ë						autopsy	ed?	prior to com death?	npletion of cause of		
Vital R sician: The certificate h rector, page	ŭ	25. Was case referred to medical				OS Blace of De	1 ☐ Yes 2 ath (Check only one		1 L Yes	2 □ No		
ysicis Carl	0	examiner?	pital: 1 ☐ Inpatient 2 🛣	EB/Outnatient	3[] DOA	Orbert			the /Conside			
1 Of 9 Phys er this	Ë	27. Manner of Death	28a. Date of Injury	28b. Time of		Injury at Work?	28d. Describe hor			)		
ion inding ith.	atio	1 XNatural 5 Pending 2 Accident investigation	(Month, Day Yeer)	Injury		Work? 1 ☐ Yes 2 ☐ No						
Division Oivision To Attending after death. Director: Afte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, larm, stre	et, factory, of	fice	281. Location (Str.	eet and Nun	nber or Rural	Route Number,		
Div	ert	4   Homicide	building, etc. (Speci	<b>(y</b> )			City or Town,	State)				
Division of Vital  Division of Vital  To the Hospital or Attending Physician: whitin 24 hours after death.  To the Funeral Director. After this certifical completely filled in by the tuneral director.		29a. Certifier 1□ Certifying Physic	ian: To the best of my kno	wledge, death	occurred at ti	he time, date and place	e, and due to the ca	use(s) and r	nanner as sta	ated.		
To the Hos within 24 h To the Fun completely	ledical	(Check only one) 2 Medical Examiner	r: On the basis of examina and manner stated.	ation and/or inve	estigation, in	my opinion, death occi	urred at the time, da	te and place	e, and due to	the cause(s)		
To t To t	Σ	29b. Signature and title of certifier	,			cense number	29	d. Date sign	ned (Month, Dey, Year)			
(1)		Southy C. Ho.				06241		9-5	-04			
641		30. Name and address of person who comp	pleted cause of death (Iter	n 23a) (Type, P								
		DOROTHY C. HO			20	03 SNOW S	OT. SNO	N HIL	, MI	), 21863		
	State istrar	31. Date filed (Month, Day, Year)	32. Begistrar's Signa	ature								

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Departs		tal Hygiene					
_				icate of Death	Reg. No.					
	Physici	an	1. Decedent's Name (First, Middle, Last)							
	/Medio Examin		4a, Facility Name (If not institution, give street and number)  4b	. City, Town, or Location of Death	4c. County of D	/				
	Ladiiii	<b>.</b>	BALLinore VAMEdiCAL CENTER	BALLIMURE		NA				
Ī	Funeral			Under 1 Year If Under 24 Hrs. 8. Donths Days Hours Min.	Date of Birth  Month Day, Year)  9.	Birthplace (State or Foreign Country)				
	Director		Usual Residence of Decedent		0-00-40	LH				
	tryland thow		10a. State 10b. County 10c. City, Town or Location	n 0 11.		10d. Inside City Limits				
	the Mg	Director	10e. Street and Number	Cof. Zip Code	10g. Citizen of What	1 Yes 2 No				
	ours after death with the Manylar ral', or items 23a or 28a-f show Evanifier must be indified st		4581 Nertry Manne More	21215	USA	Country				
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was If Ye	Decedent of Hispanic Origin? (Specify s, specify Cuban, Mexican, Puerto Ricar	Yes or No- n, etc.) 14. Race - A Black, W	merican Indian,				
36	rs afte	by Fu	1 Never Married 2 Married 1 Yes 2 No	Yes 2 No Specify:	Specify:	Rinch				
9	72 hours "natural", digal Exa	ted	15. Decedent's Education 16a. Decedent	s Usual Occupation of work done during most of working	16b. Kind of Busine	ss/Industry				
21215-0036	filed within 72 hours after death with the Maryland Hygiene. the riten "natural", or items 23a or 28a-f show ent, it is Medical Exantral must be notified at	Completed	Elementary/Secondary (0-12) Sollege (1-4or 5+)	Driver	Timongo	The sea what well				
	be filed within 72 ho tial Hygiene. sd other than "natur event, I'm Medical	ø	17. Father's Name (First, Middle, Last)		st, Middle Maiden Sumame)	STATION				
Maryland	2 should be and Mental is marked of aumatic eve	To B	Jules Fabre'	Norma F	. Perrie					
Mar	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	uress (Street and Number or Rural Roll	ute Number, City or Town, Stat	e, Zip Code)				
	l an leal leal m 2		20a. Vethod of Disposition 20b. Place of Disposition	n (Name of Date	20c. Location - City	or Town, State				
Baltimore,	permit. Pages Depertment of Himportant: If Ite any injury or of once.		1 Burial 2 Cremation 3 Removal from State	WN 9-13-	04 Battin	ore MD				
3alt)	permit. Pa Depertmen Important: any injury		21. Signature of Funeral Service Licensee	me and Address of Facility Way	hnc. Greene	Funcial Stuc				
	<u> </u>		23a Parti Enter the disease or complications that caused the death. Do not enter the	28 MOERTY KO	. Kangaist	NUN IND 213				
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart value. List only one cause on each line.  Immediate Cause (Final	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Interval Between Onset and Death				
	/Medical		disease or condition resulting in death)  a	lure		1 week				
1	Examiner	7.	Sequentially list conditions, if any, leading to immediate  b. Liver Fair  Due to (or as a consequence of):	ure		Unknown				
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause.							
o.	cate be executed bhysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):							
8760.	cate be	dicai	d							
Box 6	eath certific attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of	delivery				
B	ne death the atter	iciar	in the past 12 months?  1 Yes 2 No  4 Pregnant at time of death 5 Ott	opic pregnancy ner (specify)	Month	Day Year				
P.O.	that the d ed by the detached	Physici	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the under	Address of the Control	23e. Did tobacco use contribut	a to the equal of death?				
	uires tha signed Id be del	by	Part II, Other significant continuous continuoung to death but not resulting in the under	lying cause given in Part I.		Probably 4 Sunknown				
So	law require as been sig 2 should b	olete			24a. Was an 24b. Were	autopsy findings available				
Vital Records.	The la	Completed			autopsy prior death 1□ Yes 2□ No 1□ N					
/ita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	26. Place of Death (Ch						
	Physic this o	- To	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient :  27. Manner of Death 28a. Date of Injury 28b. Time of		5 Residence 6 Other (S	(pecify)				
ion	nding Ph ith. :: After th e funeral	ation	Natural 5 Pending (Month, Day Year) Injury	Work? M 1 Yes 2 No	and any and any any and any and any any and any any any any any any any any any any					
Division of	or Attendi efter death. Director: A	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office 28f. L	Location (Street and Number or City or Town, State)	Rural Route Number,				
Ω	pital o	Cer	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death oc	curred at the time, date and place, and (	due to the causes(s) and manner	ac stated				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or invest and manner stated.	igation, in my opinion, death occurred at	t the time, date and place, and	due to the cause(s)				
	To tll within To tll comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (M	onth, Day, Year)				
	10		Chi Chi, MD.	10/3001	7/8/2	æ4·				
	Y		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	N GREENESTREET	BALTIMORE MI	21201				
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	al s	29d. Date signed (Month, Day, Year) 9/8/2004.  Rect BALtimore. MI) 2/20/					
	Regist	rar	SEP 1 0 2004 Januar &	arti						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Rag. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 09 2004 ŏĕ 6:00a. M Faines Lillie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Pikesville Ruxton Nursing Home If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Ye 4-16-17 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral Hours 1 ☐ M 2**X** F Months Days 122-22-5226 Director N.C. 87 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Show 7 is marked other than "natural", or items 23s or 28e-f show traumatic event, the Medical Erac must be motified at Baltimore 1 X Yes 2 □ No NA Completed by Funeral Director Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code LISA 21217 1102 N. Appleton St. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic aven" Nursing Home Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Aid Hospitál 7th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hargrove Faines **Emma** ٩ Lueco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1102 N. Appleton St., Baltimore, Md. 21217 Sister Emma Rice 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ P
4 ☐ Donation 5 ☐ Other (Specify) 2 Cremation 3 DRemoval from State 9-13-04 Randallstown, Md. King Mem. Pk. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H East 1101 East North Ave, Baltimore, Md 21202 23a. P. nt. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, oc., or heart failure. List only one pause on each line. Approximate Interval Between EROSCLEROTIC Imm dia a Cause (Final dise see r condition resultion in death) EREBROL Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year for Month Day 5 Other (specify) 4 Pregnant at time of death P.O. the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Yes 2 No 3 Probably 4 Upknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed 1 Yes 2 No Vital 25. Was case referred to medical examiner? Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 ☐ Yes & No 1 Inpatient 2 ER/Outpatient 3 DOA of this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: Division Natural 5 Pending 1 🗌 Yes death. investigation 2 No 2 Accident hin 24 hours after death the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 44 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier olian 0111 285 95 and address of person who completed cause of death (Item 23a) (Type, Print) Battemore, MD 21208 SNEEM 31. Date filed (Month, Day, Year) 32. Regis State Registrar

			1 - For State Registrar	S	tate of M	larylan		artmen <i>tificat</i>					giene Reg. No		2	878	8						
	Physici	an	1. Decedent's Name (First, Middle, Last)  SYLVANNAH FOSTER						2. Date of Death  Month Day Year  A								eath A						
	/Medic Examir							September 07 2004 09 00  4b. City, Town, or Location of Death  4c. County of Death								900	/-₹ M						
			BAYVIEW	HOSP	TAL			BALTIMORE						NA									
	Funeral Director		5. Social Security Number 248-32-8228	6. Sex 1 ☐ M	2) F 7. A	ge (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. 8 Min.	B. Date of Bir (Month, Da 11-1	ı <i>y, Year)</i>	9. B	irthplace Country)	e (State or I	Foreign						
	puq *		Usual Residence of Decedent  10a. State 10b. Count	v			, Town or Lo	cation					7-20		104	Inside City	d lands						
	Maryla -f eho lied at	tor												1	1 NYes 2								
	th the	Director	10e. Street and Number					10f. Zip	Code 10					izen of What	Country	?							
36	s 23e		1239 N. Luzerne Ave.					21213						USA									
	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f ehow the Medical Examinating the notifiled at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U. Armed Forces?  1 Yes, Give  14 Yes, Give  17 Year or Dates:					13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:					)-	14. Race - American Indian, Black, White, etc.  Specify: Black									
21215-0036	thin 72 hours e. an "neturel', Medical Ex.	Completed	(Specify only highest grade completed)				16a. Deced (Give life, L	lent's Usua kind of wor	rk done d	uring mos	t of working	7	16b. K	b. Kind of Business/Industry									
212		Comp	Elementary/Secondary (0-12) College (1-4or 5+)					estic					Ot	ther People Homes									
Maryland	e d ala	Be	17. Father's Name (First, Middle Jordan		W.	Joh	nson				r's Name ( .vanna	First, Middle, h			-								
aryl	d 2 should be th and Menta 7 Is marked freumatic ev	<sup>L</sup>	19a. Informant's Name/Relation			OOI		g Address	(Street a	<del>_</del> _				or Town, State,		de)							
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ο.		by PI	Part II. Other significant condit	i <b>ons</b> contribu		1						23e. Did to	obacco u	se contribute	to the ca	ause of dear	th?						
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		11	30. Name and address of person  DEAN DAL						ew	H.C	SPIT	AL											
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item # 23a, 27, 28a-f, per ME C836, 10/8/04 TT

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27-96-4776  MD NA Baltimore  102. Code  103. Code  104. Code  105. Steel of Number  105.	Funeral	5. Social Security Number 6	1 N 2 F E	Months Days Hours	4 Hrs. 8. Date of Birth Min. (Month, Day, Ye	ar) 9. Birthplace (State or Country)
The State In the S	Director		41	Yrs.		
Harry T. Ferguson   Sequentially list conditions are considered from the cause of the death but not resulting in death but not resulting in the underlying cause given in Part I.   Due to (or as a consequence of):	<u>2</u> ≱		10c. City, Tov	n or Location		10d. Inside City
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Party T. Ferguson   Sequentials   Sequenti	ms 2		12. Was Decedent Ever in U.S.		n? (Specify Yes or No-	14. Race - American Indian,
Part   Part	or the	1 XNever Married 2 Marrie	d 1 ☐ Yes 2 🛣 No		Puerto Hican, etc.)	Constitution
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23a. Part II Enter this issues, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate and the complete complete complete cause in the cause of each line.  Approximate and the complete cause in the cause of each line.  Approximate and cause cardiac or respiratory arrest.  Approximate cause in the cause of each line.  Approximate cause in the cause of each line.  Approximate cause in the cause of each line.  Approximate cause in the cause of each line.  Approximate cause in the cause of each line.  Approximate cause in the cause of each line.  Approximate cause in the cause of each line.  Due to (or as a consequence of):  Due to (or as a conseq	ontail ced o					
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Immedical cause (Final deason or condition resulting in death)  Sequentially its conditions, disagned to memediate cause. Effect Underlying deason or condition feebling in death)  Sequentially its conditions, cause (and in any least and beat deason or condition feebling in death)  Least any least and beat deason or conditions (any) to the cause of the ca	?	23a. Part 1. Enter the disease, or c	omplications that caused the death. Do			Approximate
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Sequentially list conditions, fairly, leading to immediate cause. Enter Underlying Cause (Disease or inlury).  If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 2   Live birth 2   Fetal death 3   Ectopic pregnancy 2   Live birth 2   Fetal death 3   Ectopic pregnancy 2   Live birth 2   Fetal death 3   Ectopic pregnancy 2   Live birth 2   Fetal death 3   Ectopic pregnancy 2   Live birth 2   Ectopic pregnancy 2   Live birth 2   Ectopic pregnancy 3   Live birth 2   Ectopic pregnancy 3   Live birth 2   Ectopic pregnancy 3   Live birth 2   Ectopic pregnancy 3   Live birth 2   Ectopic pregnancy 3   Live birth 2   Ectopic pregnancy 3   Live birth 2   Ectopic pregnancy 3   Live birth 2   Ectopic pregnancy 3   Live birth 2   Ectopic pregnancy 3   Live birth 2   Ectopic pregnancy 3   Live birth 2   Ectopic pregnancy 3   Live birth 2   Ectopic pregnancy 3   Live birth 2   Ectopic pregnancy 3   Live birth 2   Ectopic pregnancy 3   Live birth 2   Ectopic pregnancy 3   Live birth 2   Ectopic pregnancy 3   Live birth 2   Ectopic pregnancy 3   Live birth 2	/Medical		<b>—</b> " — — — — — — — — — — — — — — — — — —			
Female:   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   23d. Date of delivery   Month   Day   Year   1   Year   2   No   3   Probably   4   Unknown   24d. Was an autopsy   4   Unknown   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   25   Was case referred to medical   26   Place of Death (Check only one)   Work?		Sequentially list conditions	b			
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FFEMALE:   23b. Was decedent pregnant in the past 12 months?	ician burial		Due to (or as a consequence	or).		
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	within 24 hours after death.  To the Funaral Director: After this certific completely filled in by the funeral director, I Medical Certification; To Be C	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	Physician: To the best of my knowledge xaminer: On the basis of examination a and manner stated.	29c. License number O.C.M.F	place, and due to the cause occurred at the time, date 29d.	(s) and manner as stated.  and place, and due to the cause(s)  Date signed (Month, Day, Year)

			State of Maryland / Dep 1- State of Maryland / Dep 1- State of Maryland / Dep			jiene	28790
H	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	al	Joel Marcus Griffin  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Deptemb	4c. County of Dea	
	LAdillii	-i	Union Memorial Hospital	Baltimore			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day	9. Bit	rthplace (State or Foreign ountry)
	Director		141-44-2931 Source of Decedent		12/16/		ryland
	rland wow		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	a-f st	ctor	Maryland Baltimon	re			1X Yes 2 □ No
	ith the	Director	10e. Street and Number 830 EAST ARGONNE DRIVE	10f. Zip Code	1	10g. Citizen of What C	ountry?
	s 23a	rai	830 Auburn Drive	21218		J.S.A.	
	her de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 名 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
99	ursal al', or	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: B]	lack
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Itams 23a or 28a-f show ant, the Modical Examination out the mailfied at	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of work	ina	16b. Kind of Business	s/Industry
121	within ne.	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Тистопо	
0	filed v Hygie ther t		8 I'ru	ick Driver	e (First, Middle,	Transpor	tation
an	lid be lental kad o ic eve	To Be	Joseph Griffin	Mary E.			
Maryland	should and Men s marka umatic	-		ing Address (Street and Number or Rur		r, City or Town, State,	Zip Code) Apt. 70
	and 2 Balth a n 27 is			Belvedere Ave., Ba	altimore	, Maryland	21215
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural; or Itams 23a or 28a-f show any injury or other traumatic event, the Modest Examited countries countried at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place)		20c. Location - City or	
Ë	t. Partmen					Baltimore,	
Bal	permit. Departr Imports any inji		Went C. J. 46	2. Name and Address of Facility The 11 Park Hgts. Ave.	, Balti	more, Mary	
			23a. Part 1. Enter the disease, or complications that daused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Pnysician / /Medical		Immediate Cause (Final disease or condition resulting in death)				Seven days
	Examiner		Due to (or as a consequence of):	0.0			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	cuted nd ransit	Examiner	cause (Disease or injury that initiated events c. Acquired Imm	unodeficiency.	Syndro	me	Eighteen Yrs
8760,	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):	(			
387	physi s the t	Physician/Medical	d				
Вох 6	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	livery
	death e atte	icia	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
<u>Ф</u>	at the de by the a stached	hys	9 Unknown				
Ś	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as:	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		bacco use contribute t es 2 ☐ No 3 ☐ P	o the cause of death? robably 4 <b>B</b> Unknown
Division of Vital Record	law requ as been 2 should	Completed			24a. Was a autops		utopsy findings available completion of cause of
<u>ح</u>	The cate h	Соп			perfor		
Vita	ician: certific ector.	Be	25. Was case referred to medical examiner?	26. Place of Deat			
ot	Physician: The law r this certificate has b ral director, page 2 s	1.	1 ☐ Yes 2 ∰ No			ence 6 Other (Spe	ecify)
O	iding th. th. : After s funer	tion	1 顧Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	Log. Dogonibo III	over migary obscurred	
VISI	or Attanater deat Diractor: in by the	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si	reet, factory, office	28f. Location (St City or Town	treet and Number or R	ural Route Number,
	tal or Ars after all Dirac	Certification:	4 Homicide building, etc. (Specify)		City or Town	r, State)	
	To tha Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Diractor: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cared at the time, d	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mont	
)			Me Sepplace " (VII)	ATZ438946 -	£6	9/4/0	4
	Ŋ.	[]	30. Name and address of person who completed cause of death (Item 23a) (Type Ali Esmaili Union Memorial Hos	•	Isity Purl	Kway Buttin	nore, MD 21218
	Sta Registr		31. Date filed (Month, Day, Year)  SEP 1 0 2004  33 Registrar's Signature				

			1 - State of M	laryland / Dep <i>Ce</i>	artment of H		lental Hygie	2001	28791
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Richard H. Gaskins				2. Date of Death September		3. Time of Death 2:30 A M
	Examin		4a. Facility Name (If not institution, give street and number Heartlands of Severna Park			r Location of Death		4c. County of Deat	
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Anne Arui	noel thplace (State or Foreign ountry)
	Director		579-26-9407 Usual Residence of Decedent	79 Yrs.	Months Days	Hours Min.	(Month, Day, Ye 1–2–1925		hington, D.C.
	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show the M. dical Ex., direct, ust be notified at	_	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	8a-f	Funeral Director	Maryland Anne Arundel	Edge	water				1 Yes 2 No
	with the a or 2	Dire	10e. Street and Number		10f. Zip Code			Citizen of What Co	ountry?
	eath	era	56 Ridge Avenue  11. Marital Status 12. Was Decedent	t Ever in U.S. 13	21037			JSA 14. Race - Ame	nican Indian
(0	r itan	Fun	Armed Forces 1 ☐ Never Married 2 🕅 Married 1 🕅 Yes 2 ☐	No	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, White	
93	rel', o	d by	3 ☐ Widowed 4 ☐ Divorced If Ŷes, Give Year or Dates:		1 ☐ Yes 2 📉 No	Specify:		Specify: W	nite
Maryland 21215-0036	"natu	Completed by	15. Decedent's Education (Specify only highest grade completed)	(Cino	dent's Usual Occup	during most of words	ing 16b	. Kind of Business/	/Industry
12	withir ene. than	dmc	Elementary/Secondary (0-12) College (1-4or 4 years	Direc	DO NOT use retired tor of			Federal (	Government
9	filed I Hygi other	Be Co	17. Father's Name (First, Middle, Last)	Space	Manageme	nt 18. Mother's Nam	e (First, Middle, Maid		30 VELITIMETIC
/lar	uld be Menta Irkad Itic ev	To B	William Gaskins			Ell	a Payne		
lan	2 sho and t ie me		19a. Informant's Name/Relationship (Type, Print)			and Number or Run	al Route Number, Ci		Zip Code)
	1 and Health Sm 27 ther tr		Sherron D. Gaskins/ Wife 20a. Method of Disposition				ater, MD		T
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 ie markad other than "naturel", or itams 23a or 28a-f show ery injury or other traumatic event. If a Marical Examination is be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cre			11.	. Location - City or	
뜵	artme ortent injury		`4 Donation 5 Dother (Specify)  21. Signatu of Funeral Service/Licensee	Oak Hill	Cemetery  Name and Address	9–10	-04 Wa	shington,	D.C.
Ba	Depa Impo eny ir		Vannfilales-	29	973 Solom	ons Islan	d Rd.,Edg	ewater. M	d. 21037
г			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do not en				,	Approximate Interval Between
	Physician			,	teat F	allune			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as	consequence of):	test Fardion	./	/		
		<u>_</u>	Sequentially list conditions, if any leading to immediate	s a consequence of):	ardion	Lyopat	4		
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				/		
o,	an and rial-tra			s a consequence of):					
8760,	death certificate be executed e attending physician and id for use as the burial-transit	by Physician/Medical	d						
9	as as	Med	IF FEMALE:						
Вох	that the death certific ed by the attending p detached for use as	clan/	in the past 12 months?	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of deli Month	ivery Day Year
P.O.	tt the d by the tached	nysie	1  Yes 2  No 9  Unknown 9  Unknown	at time of doubt					
S, D	res that igned b	y PI	Part II. Other significant conditions contributing to death	but not resulting in the u	inderlying cause give	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ord	w require been sig should b				_		1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Unknown
Vital Record	The law requires that the take has been signed by the bage 2 should be detache	Completed		. <u>-</u>			24a. Was an autopsy	prior to d	topsy findings available completion of cause of
E H							performed 1 ☐ Yes 2 ☑		2 □ No
Z.	Physicien: this certificatal director, I	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpati		ot 30 DOA Othe		(Check only one)	w.	Assisted
of	문 두 등	-	27. Manner of Death 28a. Date of Inj	ury 28b. Time o	f 28c. Injury	y at	me 5 Residence		city) Living
lo	ath. r: Afte	atio	1 ☑Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	ay Year) Injury	Worl M 1□	k? Yes 2 □ No			
Division of	or Atte	Certification:	3 Suicide 6 Could not be determined 28e. Place of In building, e	njury - At home, farm, str tc. (Specify)	reet, factory, office		28f. Location (Street City or Town, St	and Number or Ru ate)	ıral Route Number,
Ω	urs af urs af arel D					<u> </u>			
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner s	of examination and/or in	h occurred at the tim vestigation, in my or	ne, date and place, pinion, death occurr	and due to the cause ed at the time, date	r(s) and manner as and place, and due	stated. to the cause(s)
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Me	29b. Signature and title of certifier		29c. License	e number	29d.	Date signed (Month	h, Day, Year)
1	1		· Keith Wanshu	$\circ$	DS	7019	SPI	) tember	- 3,2004
	15		30. Name and address of person who completed cause of			land Roa	ed 1	action to	-3,2004 D2140/
	Sta	te		rar's Signature		land Roa	u Hnna	pous, mi	26170/
	Registr		SEP 1 0 2004	w & A	mode				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Frank Nicholas Gentile September 6 2004 12:30 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1103 Collison Road Mayo Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ₹ M 2 □ F Hours Director 157-22-0843 Yrs 73 Dec. 30,1930 New Jersey Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23a or 28a-f show other treumatic event, the Medical Evanimar resist the redified at XXYes 2 □ No VA Director Alexandria City Alexandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 Prince Street, #514 22314 IISA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after of and Mental Hygiene. Black, White, etc. 1 Never Married XX Married XXYes 2 □ No Baltimore, Maryland 21215-0036 1 Yes XXNo þ Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Agent New York Life 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Antonio Gentile Antoinette Caggiano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other treum <u>once.</u> Eunice M. Gentile (Wife) 1600 Prince Street, #514, Alexandria, VA 22314 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Fairfax Memorial Park 9-11-2004 Fairfax, VA 21. Signature of Funeral Service Licensee <sup>22</sup> Hardesty Funeral Home, P.A. Dal 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RI Mar disease or condition resulting in death) 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): use as the burial-transit certificate be executed and Due to (or as a consequence of): physician Box 68760 Physician/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Š Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? Division of Vital 1 Yes 1 ☐ Yes 2 ☐ No 2 No Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. investigation М 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 T Homicide 24 hours a 29a. Certifier KCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0031998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis M2 140/ 116 delenge thung MICHELE SMADTA-GORDON M.D, 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** September 8 2004 1:29 Gray /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 7, 193 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 XF 73 Yrs. North Carolina Director 221-18-7010 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ages 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene and Health and Mental Hyglene at It lear 27.9 is marked other then "natural", or terms 23a or 28e-f show or other traumatic event, the Modelal Exeminer must be notified at 1 ☐ Yes XXNo Director Anne Arundel Deale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5652 Nutwell-Sudley Road 20751 USA Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles David Goodrich Wilda Beach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 William Gray (Son) 726 Shady Oaks Road, West River, MD 20778 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Pag Department Important: f any injury o Metro Crematory 9-13-2004 4 □ Donation 5 □ Other (Specify) Baltimore, MD P.A. Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 21. Signature of Euneral Service L alust 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition vaocular accident Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of): Examiner burial-transi Due to (or as a consequence of) 1010 Exp. 9-8-04 Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year to Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ormed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 Inpatient examiner?
1 Yes 2D No
27. Manner of Death
1 Natural 5 Other: 2 ER/Outpatient 3 DOA ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) o 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: ion ( Injury 5 Pending 1 Tyes 2 No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the -186 Divisi 6 Could not be determined 3 □ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of reviified September 8,2004 10060535 eted cause of death (Item 23a) (Type, Print) 30. Name and address of person y Nadia Angov, MD 624 Healthway Drive, Berlin, MD 21811 31. Date filed (Month, Day, Year) SEP 1 0 2004 32. Registrar's Signature State Speed Registrar

DHMH 17 Rev 1/2001

Stace

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	RJ		1 - For State Registrar	pend Ite	m #23a,27,2	28a-f	per m	e G835	5/16/04 C	tas	ygien	e .0001		to seems and
			Decedent's Name					oato or	Douin	2. Date of D		10.	3. T	ime of Death
	Physici		John	Edward	Gorozdos					Septem		7, 2004		21 P. M
	/Medio Examir		4a. Facility Name (II	f not institution, g	give street and number)			4b. City, Town,	or Location of De		-	c. County of De		<u>~1 1 •</u>
			4001 Dane	ce Mill	Road			Phoen:				Baltimor	e Cou	inty
20	Funeral		5. Social Security N		.Sex 7.Ag 1.2≸M 2.☐F	e (In yrs. last	birthday) Yrs.	Months Days		in. (Month, L	Jav. Yea	9. B	irthplace (5 Country)	State or Foreign
J	Director		216-92-77 Usual Residence of			40	1.0.			Sep. 2	./, I	963   was	sningi	ton,DC
	yland		10a. State	10b. County		10c. City, To		ation					10d. Ins	ide City Limits
	Ba-f s	ctor	MD	Baltim	ore	Phoe	nıx						10	Yes 2X No
	vith th	Director	10e. Street and Nun		D 1			10f. Zîp Code			10g. C	Citizen of What (	Country?	
	s 23e	Funerai	4001 Dan	ce Mill	Road 12. Was Decedent	Ever in U.S.	12.14	21131	Literania Origin?	/Consider Versions h	1-	U.S.A.	ariana ladi	
10	fter de	Fun	11. Marital Status  1 XNever Marri	ed 2□ Married	Armed Forces?		IS. V	Yes, specify Cul	ban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	10-	Black, Wh		ian,
5-0036	al', or	þ	3 Widowed	_	If Yes, Give Year or Dates:		1	☐ Yes 2 🛣 No	Specify:			Specify: V	Vhite	
5-0	72 ho	Completed	(Spec	15. Decedent's	Education grade completed)	16	6a. Deced	ent's Usual Occu	ipation a during most of y	vorkina	16b.	Kind of Busines	s/Industry	
121	within ne.	mpi	Elementary/Seco		College (1-4or		life. D	O NOT use retir	ed) R	lepresen-	Ha	armonia	Mundi	i
121	Hygie Hygie ther t		17. Father's Name	(First Middle La	St) 4	58	ares	and Mar	keting t	ative lame (First, Middi	la Maide	an Sumame)		
ano	d be i	o Be	Richard		*					a Gaylor		,,, camano,		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. titem 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Ever in at must be redified at	_	19a. Informant's Na David Go			1:			at and Number or	Rural Route Num Glen Bur	ber, City			
	of Health of Health litem 27 i		20a. Method of Disp			20b. Place	of Dispos	ition (Name of		Date	_	Location - City of		ate
ē	Pages nent of I int: If its		1 □ Burial 2 [ 1 □ Donation		Removal from State			atory`or other pla Crem.	atory9-0	9-04	Laı	ırel, MI	)	
Baltimore,	+ E # -		21. Signature of Fu							eck Fune				
ä	Depa Depa Impo any ir once		PKRU	astew	art 40	1338	760	1 Sandy	Spring	Rd. Laur	e1,	Md 2070	7	
			23a. Part1. Enter	disease, or control failure. List or	mplications that caused by one cause on each li	d the death. D	o not ente	r the mode of dy	ring, such as card	iac or respiratory	arrest,		Interv	oximate al Between t and Death
60,	/Medical Examiner physician and the prizal-transit the prizal-transit	ai Examiner	Immediate Cause (disease or condition resulting in death)  Sequentially list confidence in the cause. Enter Under Cause (Disease or that initiated events resulting in death) I	nditions, madala rlying injury	Due to (or as b. Due to (or as	a consequence	ce of):	ted by 1	Vitrous	Oxide an	d Al	cohol I	ntoxi	cation
68760	physicia pthe bur	dica			d									
P.O. Box 6	attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1  Yes 2 9 Unknown	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea	ath 3 🔲	Ectopic pregnani Other (specify)	су			23d. Date of d Month	elivery Day	Year
	es that the de igned by the be detached	y Ph	Part II. Other signif	icant condition	s contributing to death b	out not resulting	g in the un	derlying cause g	Iven in Part I.	23e. Did	tobacco	use contribute	lo the caus	se of death?
rds	quires n sign	ed by								_ 1□	] Yes	2 200 3□1	robably	4 Unknown
00	aw requii s been s s should	Completed								24a. Wa		24b. Were	autopsy find	dings available n of cause of
R	The late ha	mo								per 1 Yes	opsy formed? 2 \(\sumbed\) N	death?		
ita	sician: The law s certificate has t lirector, page 2 s	Be	25. Was case references	red to medical					26. Place of E	eath (Check only				
Division of Vital Records,	ding Physician: The n. After this certificate ha funeral director, page	ျ	1 XYes 2□		Hospital: 1 ☐ Inpatie		Outpatient	JE DOX		Home 5□Res			ecity)At	scene
ou c	ding F	ion:	27. Manner of Deatl  1 □Natural	5 🗌 Pending	Pound	ry Year) <b>F</b> o	b. Time of Injury OUNG	28c. Inju	uryat ork? ]Yes 2.∭TNo	28d. Describe				
isic	death. ctor: A the fu	icat	2 Accident 3 Suicide	investiga 6 ☐ Could no	9/7/04	7	-15	P					Rural Bou	-Minnhor
ò	al or A after Direct	Certification:	4 🗌 Homicide	determin	28e. Place of Inj building, et	c. (Specity)	t tub	or, raciory, office	,	Phoeni	wn, Sta	₩D MD	ince I	H'TT' Roa
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	1☐ Certifying 2 Medical Ex	Physician: To the best aminer: On the basis o and manner sta	of my knowled	dge, death	occurred at the	time, date and pla opinion, death of	ice, and due to the	e cause(	(s) and manner a	as stated. le to the ca	use(s)
_	within To th	Me	29b. Signature and	title of certifier		0		29c. Licer	ise number		29d. D	ate signed (Mor	ith, Day, Ye	ear)
			) Ca	rol Ht	llain i	ud		OCI	Æ		Se	eptember	8, 2	004
			30. Name and addr	ess of person who	LLAN WA	eath (Item 23a	а) (Туре, Р 111	Penn St	treet, B	altimore	, Mã	ryland	21201	
	Sta		31. Date filed (Mon.	th, Day, Year)		ar's Signature			•					
	Regist	ar	21	SEP10	2004 50	neva	B	loa	El					

			1 - For State Registrar	State of M	arylan		artment o			and M		giene Reg. No.	004	28795
	Physici		1. Decedent's Name (First, Middle, La	JOYCE	CR	KA.					2. Date of De. Month	ath Day	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, giv			,	4b. City, Tov	vn, or L	ocation o	of Death	08	2.0 4c. (	2004 County of Death	
	ZXXIIII		UNIVERSITY OF M	ARYLAND M	16 Dic	AL CTR	BAL	IIN	ORE	e , !	MD		-	MORE
	Funeral		5. Social Security Number 6. S	Sex 7. Ag	je (in yrs.	last birthday)	If Under 1 Y Months D	ear ays	If Under:	Min.	8. Date of Birt (Month, Da Aug 29,	h y, Year)	9. Birth	nplace (State or Foreign
	Director		None Usual Residence of Decedent	W ZLI		Yrs.				Min.	Aug 29,	200	4 Mar	yland
	ow ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Lîmits
	a-f sh	tor	MD Prince	George's		Sui	tland							1 ☐ Yes 2X No
	th the	Director	10e. Street and Number				10f. Zip Co	de				10g. Citiz	en of What Cou	untry?
	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show he Medleal Evantriar must be rollified at	ral	3901 Suitland Ro	ad					0746				USA	
	er dez Itams	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13. \	Nas Decedent f Yes, specify	of Hisp Cuban,	panic Orig Mexican	gin? (Spo , Puerto	ecify Yes or No Rican, etc.)	- 1	<ol> <li>Race - Amer Black, White</li> </ol>	
36	rs aft	by F	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📉 If Yes, Give Year or Dates:	No		1 □ Yes 2 🔯	No	Specify:				Specify: b	lack
9	2 hou atura	ted	15. Decedent's E	ducation			dent's Usual O					16b. Kin	d of Business/li	ndustry
215	thin 7 e.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or !	5+)	(Give life. L	kind of work d DO NOT use n	lone dui etired)	ring most	t of work	ing			·
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pu	be fill tal H d off	Be	17. Father's Name (First, Middle, Last	)			uı	nk 1	8. Mothe		e (First, Middle,		Sumame)	
7	d Mer marke maric	10	10a Informantia Namo/Relationship	Tuna Print)		10h Mailie	on Andriana (Co		- d & ( , b		ynthia (		T Ch 7	- 0-41
Ma	d 2 sl th an traur		19a. Informant's Name/Relationship ( UMMS	Type, Print)		1	_				al Route Numbe Baltimo:			
ē,	Heal Heal tam 2		20a. Method of Disposition			lace of Dispo	sition (Name o	of			Date		ation - City or T	
Ö	Pages ent of nt: if i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 🕅 Other (Special			emetery, cren	natory or other	r place)						
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If itam 27 is marked other than "naturat", or itams 23a or 28a-f show any injury or other traumatic event. The Medical Examinational Bear collised at ORGE.		21. S natur of Funeral Service Lice Ronal S.								655 W.	Ba1t	imore :	Street
			23a. Part1. Enter the disease, or com	plications that caused	the deat		1timor er the mode of			2120 cardiac c		rest,		Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	PRE-VI		E								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as					-					
ı	Examiner		Conventially list and divine	h										
	p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence of):								
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Вох	death certificate be executed e attending physician and ad for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			-					23	3d. Date of deliv	ery .
m .	he death the atte	lcla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at			Ectopic pregn Other (s <i>pecif</i>						Month	Day Year
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900	law requas been 2 should	Completed									24a. Was autop		24b. Were aut	opsy findings available ompletion of cause of
Ä	The lav ate has page 2	mo.	-								perfor	med? 2 No	death?	
/ita	cian: artific rctor,	Be (	25. Was case referred to medical examiner?					2	26. Place	of Death	(Check only o			
) (	Physician: r this certific ral director,	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie		ER/Outpatien		Other:	4 🗀 140		me 5□Resid			fy)
Division of Vital Records,	ttanding F death. ctor: After i y the funera	Certification;	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio		y Year)	28b. Time of Injury		Injury a Work? 1  Ye			28d. Describe h	iow injury	occurred	
Divis	al or Atta s after de il Diracto id in by th	Sertific	3 🗍 Suicide 6 🗍 Could not b 4 🗍 Homicide determined		ury - At ho c. <i>(Specif</i> )	ome, farm, stre	eet, factory, of	fice			28f. Location (S City or Tow		Number or Rur	al Route Number,
	To the Hospital or Atlanding Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical (	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	nysician: To the best miner: On the basis o and manner sta	f examina	wledge, death tion and/or inv	occurred at the	ne time, my opin	, date and nion, deat	d place, th occurr	and due to the ded at the time, d	cause(s) a date and p	and manner as solace, and due t	stated. to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	0				cense r					signed (Month,	
			I adora Wone	di, MoD	),		DO	106	FOL	-8		08	129/2	POOH
			30. Name and address of person who	completed cause of d	leath (Item	23a) (Type, 2 Sout	Print) 1 L aree	ne	St	UN	ıms	Balt	129/2	0_
	Sta		SEP 1 0 2004	32. Registr	ar's Signa		lone							
	Registr	ar				- 14	runs							

	Physicia	n	For State AMEND ITEM #3  1. Decedent's Name (First, Middle, Las	1)		tin <del>d</del> aterof	Death	2. Date of Deat Month	h Day Year	3. Time of Death
	/Medic Examin	al -	4a. Fecility Name (If not institution, give	<u> </u>	GRAY		or Location of De	ath	4c. County of Death	1.40PM
	Funeral Director		5. Social Security Number 6. Se		yrs. last birthday) Yrs.	If Under 1 Year Months Days			9. Birth Cou 2004 Mary	place (State or Foreign rity) 'Land
:	within /2 nours affer death with the Maryland ene. Itan "naturat", or items 23a or 28e-f show re Madical Examiner must be notified at	ector	10a. State 10b. County	George's	City, Town or Lo	cation tland		1	0g. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2√ No
	eath with	eral Dir	3901 Suitland Roa	ad  12. Was Decedent Ever i	0115 13.1		20746	(Specify Yes or No-	USA	
9600	ours affer d urat, or Item	d by Funeral Director	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cul	an, Mexican, Pue	erto Rican, etc.)	Black, White, Specify: b1	etc. _ack
21215-0036	d within 72 r giene. ir than "natu ir e Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) none	College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of w	vorking	16b. Kind of Business/In	dustry
밀	z should be filed within and Mental Hygiene. Is marked other than aumatic event, It a Ma	To Be C	17. Father's Name (First, Middle, Last)			unk		ame (First, Middle, M ia Gray	Maiden Sumame)	
re, Mar	is 1 and 2 should be filed within 12 hours affer death with the Maryla of Health and Menhall Hygione. I them 23 a or 28e-1 show them 27 is marked other than "natural", or Items 23a or 28e-1 show other traumatic event, the Madical Examinar must be notified at		19a. Informant's Name/Relationship (7 UMMS 20a. Method of Disposition		22 S	G. Greene	Street	Baltimore	City or Town, State, Zip.  MD 21201  20c. Location - City or To	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tra ODCs.	-	1 Burial 2 Cremation 3 Cher (Specify 21. Signature of Funeral Service Licens	in state7		. Name and Addr		rd 655 W	Baltimore S	Stroot
	Thysician and /Medical strains and parall-transit the parial-transit	Exa	23a. Pam. Enter the disease, or composition, or heart failure. List only of limmediate Lause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	eath. Do not ent  AGILIT  sequence of):  sequence of):	er the mode of dy	ing, such as cardi	ac or respiratory arre	ost,	Approximate Interval Batween Onset and Death
.O. Box 68760,	e attending p	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	etal death 3	Ectopic pregnand	·y		23d. Date of deliver	ery Day Year
₾ ;	se de les	d by PI	Part II. Other significant conditions co	entributing to death but not	resulting in the u	nderlying cause g	ven in Part I.		acco use contribute to to	
۳ ,	ate h page	Completed				1000 00 000 00 00 00 00 00 00 00 00 00 0		24a. Was ar autops perform 1 \( \text{Yes} \) 2	v prior to co	psy findings available impletion of cause of
of Vita	rnysician: In this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manper of Death		2 ER/Outpatier	1 3 DOA	her: 4 🗆 Nursing	eath (Check only one Home 5 Reside 28d. Describe ho	nce 6 Other (Specif	(y)
ivision	to the nospital of Attending Physician, within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;	Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Yea. 28e. Place of Injury - A building, etc. (Sp			Yes 2□No		reet and Number or Rura	al Route Number,
	vithin 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exem	vsician: To the best of my iner: On the basis of exam and manner stated.	knowledge, death nination and/or in	occurred at the treestigation, in my	ime, date and pla opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner as s ite and place, and due to	tated. the cause(s)
•	vithir To th comp	Me	29b. Signature and title of certifier  Addra	Nonedi,	MD	h	se number 70610-		Od. Date signed (Month,	Day, Year)
			30. Name and address of person who o	1 4 0		Print) Hene St,		Baltin		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23 State of Maryland / Department of Health and Mental Hygiene 1- State Pr., Go35, 09/10/10/40/hb. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WILEY GILLIAM 37 29, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore ///ary/and 5. Social Seburity Number 40spital General 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 212-30-0087 1520M 2□ F Director Yrs. MD Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Medical Examinations the natified at 10d. Inside City Limits NIA MD BALTIMORE Director 1 XYes 2 □ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 827 WASHINGTON BLVD U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 21 21No If Yes, Give Year or Dates: Specify: BLACK 1 ☐ Yes 25€No Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "any injury or other treumatic event, the Mean once. Elementary/Secondary (0-12) College (1-4or 5+) SECURITY BANK. 8th anade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be PLUMMER GILLIAM MARYLOU BARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERIC GILLIAM 827 WASHINGTON BLVD BALTO MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 09.03.04 BALTIMORE, MD MT. ZION <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
VAUGHN C. GECENE FUNERAL SERVI
SIGI BALTIMORE NAT'L PIKE BALTO an MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia **Physician** nours /Medical Due to (or as a consequence of): Examiner Mechanical Ventilation 20UB Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine to (or a a consequence of): certificate be executed burial-transit echanien and resulting in death) Last Due to (or as a consequence of): the attending physician ned for use as the burial 68760 Physician/Medical Box ( IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0 9□ Unknown 9 ☐ Unknown b cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by rabetes 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown nsion 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe res 2 certificate Vital 1□ Yes Hospital or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 patient 2 ER/Outpatient 3 DOA of 28a. D te of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division After Natural Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after deati To the Funerel Director: completely filled in by the 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastingtion in my occurred dath. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) socodoctologe (MI)

State Registrar

istrar SFP 1 0 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JEREMIAH HILTON - BEY SEST. **Physician** 2 004 CAMERON 1125AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MEDICAL 4c. County of Death Examiner UNIVERSITY OF MARYLAND BALTIMORE CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

MACY LAND 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 № 2 □ F Director 215-69-7440 5 23 3/25/04 Usuel Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itams 23a or 28a-f show the Medical Exercit er most be notified at 14 Yes 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3810 Reisterstown Road 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black ieted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Comple filed within Hygiene. other then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygient important: If Itam 27 is marked othar the any Injury or othar traumatic event, Ital. 2006. 0 None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kelly Hilton-Bey Melanie Ann Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3810 Reisterstown Road, Baltimore, Maryland 21215 Melanie A. Smith / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 09/11/2004 Landsdowne, Maryland 21. Stylure of Funeral Service Live 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lime. Immediate Cause (Final CORPULMONALE Priysician weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEVERE BRONCHOPULMONARY DYSPLASIA 4 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): 5 months Examiner enging physician and use as the burial-transit PREMATURITY 23 days EXTREME that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? NECROTIZING ENTEROCOLITIS 1 Yes 2 No 3 Probably 4 Unknown CTRADE III INTRAVENTAICULAR HEMORRHAGE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed TOTAL PARENTERAL NUTRITION CHOLE STASIS 2 No 1 ☐ Yes 2 2 100 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No s after death.

I Diractor: After this od in by the funeral d 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours a

To tha Funaral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 5, 2004 Clace Eller D33573 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N5W68, 22 South Greene Street, Baltimore Renee Ellen Fox MD

State Registrar

SFP 1 0 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ma	iryiand				Death	mental Hy	rgiene Reg. No.	11. 2	2700
			1. Decedent's Name (First, Middle, L	ast)						2. Date of D	eath		3. Time of Death
	Physici		Virginia Hicks							August	31, 2	Year 2004 1	L2:28 PM
7	/Medic Examin		4a Fecility Neme (If not institution, g	ve street and number)					4b. City, Town, or				.2.20 FM
	Funeral Director	÷.		l Hospital Sex 7. Age 1□ M 2∏ F	(In yrs. les	st birthday) Yrs.	If Under	er 1 Year Days	Crisfi If Under 24 Hrs Hours Min	8. Date of Bi	nth ay, Year)	omerset 9. Birthplac Country Virgi	ce (State or Foreign
	D >		Usual Residence of Decedent  10a, State 10b, County		10- Ch.	Town or Loc	-4:						
	e Maryla e-f sho	ctor	MD Somers	et		Crisfi						100.	. Inside City Limits 1 ☐ Yes 2 ☑ No
	章 2g 中	Se l	10e. Street end Number				10f. Z	ip Code			10g. Citizen of	What Country	?
	ath w	ral	201 Hall Highwa	·					21817			SA	
020	urs efter de el', or frema Examiner u	by Funeral Director	11. Merital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		1		edent of Hecify Cub 200 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or Note to Rican, etc.)		ce-American ck, White, etc v: White	
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Introcrant: I flem 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ede completed) College (1-4or 5-		16a. Decede (Give k life. D	O NOT	use retire		rking	16b. Kind of B	_	try
გ ე	Hygie ther	8	17. Fether's Name (First, Middle, Las	0				iouse	ekeeper	me /First. Middle	, Maiden Suman	home	
a	d be ental	To Be	Benjamin Harr								ine Pott	,	
ary	shoul nd Man	F	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Addres	s (Street	and Number or R				ode)
Ž	alth a 27 is	1	Minnie Stewart/	sister		P.O.	Box	17	Elk Mill:	s MD 2	1920		
Baltimore,	Pages 1 anent of He ment of He ment: If item ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 🖾 Other (Speci	Removal from State	20b. Plac	e of Dispos letery, crem	ition (Na	me of		Date	20c. Location -	City or Town	, State
Balt	pemit. Departimont		21. Signature of Funeral Service Lice Ronal of S	Wade Dire	ctor	Sta	ate.	nd Addre Anato ore,	ss of Facility Omy Board MD 2120		Baltimo	ore Sti	reet
			23a. Part . Enter the disease, or conshock, or heart failure. List only	polications that caused one cause on each line	the death.					c or respiratory a	rrest,	Int	oproximate terval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a		Asc	VI	$\sim$				Or	nset and Death
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	v requires that the death certificate be executed been signed by the ettending physician and should be detached for use as the buriel-transit	edical Examiner	Sequentially list conditions, if ery, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or a	s e consequ	ence of)	:				- !	
68760,	sician burie	Cal	cause. Enter Underlying Cause (Disease or injury that initiated events	c	uo to /or or							i	
	rdificate ng phy s es the	_	resulting in death) Last		rue to (or as	s a conseque	ence or)					!	
XON I	ath ce ttendi or use	Physician/N	•	d							Workers .	1	
0	the e	ysic	Part II. Other significant conditions	contributing to death but	not resultir	ng in the und	derlying	cause giv	en in Part I.	23b. Did	tobacco use co	ntribute to the	e cause of death?
s, P.O	requires that the death cer been signed by the ettendir should be detached for use	by Ph								1	Yes 2 No	3 Probab	ly 400 Unknown
<b>8</b> .	law require las been si 92 should l	Completed by								24a. Was perfo	an autopsy med?	availal	autopsy findings ble prior to etion of cause th?
<u> </u>	hysician: The law his certificate has b il director, page 2 s	5								10	Ves ZXINU	1 □ Y	es 2 No
<u> </u>	entific ector	Be	25. Was case referred to medical examiner?	Hospital:				104	or	ath (Check only o			-
5	Physic this cral dir	2	1 ☐ Yes 2 No 27. Manner of Death	1 Mnpatien		Outpatient b. Time of			+□ Nuising F		dence 6 Oth		
ם :	dlng h. After fune	힐	1 Netural 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey	Year)	Injury	м	28c. Injur Wor	k? Yes 2 ∐ No	200. Describe	how injury occur	90	
	• Hospital or Attending Ph 24 hours effer death. • Funeral Director: After th letely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	e 200 Place of Injur	ry - At home (Specify)	e, farm, stree	et, factor			28f. Location (: City or To:	Street and Numb vn, State)	er or Rural Ro	oute Number,
	• Hospital of 24 hours el Euneral D		29a. Certifier 1 Certifying Ph (Check only one) 2 Medicat Exam	nysiclan: To the best of niner: On the basis of e and manner state	examination	dge, death of end/or inve	occurred estigation	at the tin	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place, a	unner as stated and due to the	d. e cause(s)
	vithin 2 To the comple		29b. Signature and title of certifier			_	29	c. Licens	e number		29d. Date signed	d (Month, Day	, Year)
	-		$\rightarrow \sim$	1 + 0	7			D.	48098		8/3	31/04	
		1	30. Name end e dress of person who	completed cause of de	eth (Item 23	Ba) (Type, P	rint)					. ,	
			Vijay Karumbunat	han, M.D.	- 201	Hall	Hig	hway	- Crisf	ield, Ma	ryland 2	21817	
	Stat Registra	e	31. Date filed (Month, Day, Year) SEP 1 0	2004 32. Flegistrer	's Signature	x de	ode	1			_		

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yea 55 P M Month **Physician** EPTEMBER 08 2004 HENR MARYANN /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year **Funeral** Days 1 M 2 T Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "netural", or items 23a or 28e-f ahow other treumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Wooden Funeral 14. Race · American Indian, Black, White, etc. ent Ever in U.S. 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "n any injury or other treumatic avant 17. Father's Name (First, Middle, Last) other's Name (First, Middle, Maiden Sumame Be 20b. Place of Disposition (Name of cemetery, crematory of other Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): Examiner DROMARY LARTERIES DISERSE Sequentially list conditions, It any, loading to infinitely accesses. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 21X No 1 Yes Yes To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending hours after death. investigation 1 Tyes 2 No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m this m.o September 08th, 2014. 00041410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOGINDER P MEHTA RANDAUS TOWN CENTER MORTHWEST

Registrar

31. Date filed (Month, Day, Year)

32. Register's Signature

SEP 1 0 2004 >

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 2004 AM Deptember /Medical 4a. Facility Name (If not institution, give street and number)
Baltimore Rehabilitation Extended Care 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Days 1 XM 2 F 253-28-9783 Yrs. Director 1-19-17 Ga. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic evant, the Medical Exercities trust be notified at Director 1 X Yes 2 □ No Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a 2566 Cecil Ave. 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyres 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after a and Mental Hygiene. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No þ 3. Widowed 4 □ Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Montibello Hosp. Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Chef State of Md. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rev. James Heath Nettie Lou UNKN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 is n any injury or other traum 2634 Aisquith St., Baltimore, Md. Willie Heath, Jr. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 9-11-04 Holly Hills Cem. Middle River, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. l ad Warre March F.H. East 1101 E. North Ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Esophageal Carcinoma Physician disease or condition resulting in death) /Medical betructive Pulmonary Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Box 68760 Physiclan/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 🗌 Probably 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed Yes 2 No 1 ☐ Yes Division of Vital To tha Hospital or Attanding Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28d. Describe how injury occurred After Injury at Work? 5 Pending investigation death. 1 ☐ Yes 2 ☐ No al Diractor: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) September 4, 2004 30 Name and address of person who completed cause of wills to MD, 3900 Loch Raven Boulevard Battimore, MD. 21218 31. Date filed (Month, Day, Year) 32. Regis ar's Signature Registrar

		1	For State Registrar	State of I	Maryland / D		rtment of I		Mental Hy	giene Reg. No.	04	28802
	Obveision		1. Decedent's Name (First, Middle, La	st)					2. Date of De			3. Time of Death
	Physiciar /Medica	1	Jane Elizabeth								2004	11:00A <sup>M</sup>
	Examine	r	4a. Facility Name (If not institution, giv		er)			or Location of Death	h		nty of Death	
		4	Suburban Hospita  5. Social Security Number 6. S		Age (In yrs. last birtl	hday)	Bethes		8 Date of Bi	Mon	tgome	
	Funeral Director			I M 2 12 F		rs.	Months Days	Hours Min.	8. Date of Bi (Month, Da March	19, Year)	Mary	place (State or Foreign ntry) 1 and
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faryla	shov tag		10a. State 10b. County	1	10c. City, Town							10d. Inside City Limits 1 ☐ Yes 2 No
the M	28a-f	2	Maryland Howard	1	ETT	ico	10f. Zip Code			10a Citizan a	f Mhat Cau	
with	3a or	5	10027 Fox Den Co	nirt			,	.043		10g. Citizen o		nuy r
death	r Items 23a or 28a-fs ring ring be notified		11. Marital Status	12. Was Decede	nt Ever in U.S.	13. W		lispanic Origin? (Si an, Mexican, Puero	pecify Yes or No	)- 14. R	ace - Ameri	
36 after	or its		1 ☐ Never Married 2 ☐ Married	Armed Force 1  Yes 2 lf Yes, Give			Yes, specify Cub ☐ Yes 21K No		o Hican, etc.)	i	ack, White,	etc.
OO Sunor	al Exer		3 XWidowed 4 □ Divorced	Year or Date						Spec	Whi	
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yla ovid a	Ment warke	2	Harry Clark					Elizabe				
Baltimore, Maryland 21215-0036	Department of Health and Mental Hygiene. Importents if item 27 is marked other than "natural", or items 23s or 28s-f show may injury or other treumatic event, "he Medical Evant acroust Le notified at once.  To Re Commission by Euneral Director		19a. Informant's Name/Relationship (					and Number or Ru				
<b>.</b> 1 av	Healt tem 2 Sther	1	Jane Teslik (Dat 20a. Method of Disposition	ighter)	20b. Place of I	19 Disposi	WOODDINE ition <i>(Name of</i>	Street	Chevy Cl	ase, M		
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Ex	Medical aminer aminer		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	i line.	f): ():	the mode of dyn	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
TN, JAN STON SP.O. Box 68760, that the death certificate be exp	been signed by the attending physician and should be detached for use as the burial-transit effect by Physician/Medical Examir		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4∏Pregnant 9∏Unknown	2 Fetal death at time of death	5 🗆 (	ictopic pregnancy Other (specify)		220 Did t	М	ate of delive	ory Day Year  The cause of death?
Sords,	signe d be	1	INTINONI TIMET IN	Dection	r but not resulting in t	uro urio	ionying cause giv	en in raiti.		es 2 No		ably 4 □Unknown
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He is	certificate has been s rector, page 2 should Be Completed	-							autop	sy med?	prior to cor death?	osy findings available inpletion of cause of
TO E	tor, p	2	25. Was case referred to medical					26. Place of Deat		2 No	1 🗆 Yes	2 No
S C C S Vita	this cer al direct		examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa	tient 2 ☐ ER/Outp	atient	3 DOA Oth	er: 4 🗆 Nursing Ho			her (Specify	7)
Z u g	After funer		27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation			me of ury	28c. Injun Worl	y at k? Yes 2 □ No	28d. Describe h			
Division Attent	el Director: After ed in by the funera Certification:		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of I	njury - At home, farn etc. (Specify)	n, stree	t, factory, office		28f. Location (S City or Tox	Street and Num n, State)	ber or Rura	Route Number,
Div To the Hospital or	Medical Certificat		one)	ysicien: To the bes niner: On the basis and manner:	st of my knowledge, of examination and/ stated.	death o	stigation, in my o	pinion, death occur	red at the time,	date and place,	and due to	the cause(s)
٩	To t	2	29b. Signature and title of certifier	4.5			29c. License	number		29d. Date signe	ed (Month, L	Day, Year)
			1 1 Jan	mD			D00 8	0117		seylemb	er 8,	2004
	20		10. Name and address of person who of Eric J. Park, M.D.	completed cause of 1 990	i death (Item 23a) (T Medical Ce Irar's Signature	уре, Pr	int)  Drive =	Rochille	WD 21	450		
	State			32. Reg	rar's Signature		, 411,44	ישיון זיקטיין	,	300		
	Registrar		SEP 10	2004	irar's Signature	1	well					

			State of Maryland / Dep	artment of Health and Mertificate of Death	0001
	,	1	1. Decedent's Name (First, Middle, Last)	Tillicate of Death	Reg. No. 3. Time of Death
	Physici /Medic		Patrick Henry Hume		September 4, 2004 5:00 P.M.
2	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Ä		Crofton Convalescent Center	Crofton	Anne Arundel
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 93 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) VA
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation	10d. Inside City Limits
	Mary -1 aho	tor	MD Anne Arundel Crofton		1 ∑Yes 2X No
	or 288	irec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	23a c	ral	2131 Davidsonville Road	21114	U.S.A.
980	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow amy injury or other traumatic event, the Medical Exciting multiple mylling at anone.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	thin 72 ho e. an "natura M. o'call	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	16b. Kind of Business/Industry
2	led wi lygien her th		5+ Atto		Law
land	ild be til lental H rked ott ilc even	To Be	17. Father's Name (First, Middle, Last)  Thomas L. Hume		e (First, Middle, Maiden Sumame) rtrude Cox
Mary	2 shour and N is mai	-	The state of the s	ing Address (Street and Number or Rura Davidsonville Rd.	al Route Number, City or Town, State, Zip Code) Crofton, MD 21114
re, l	s 1 and of Health item 27 other t		20a. Method of Disposition 20b. Place of Disposition	osition (Name of	Date 20c. Location - City or Town, State
ltimore,	Page tment c tant: If jury or		'4 □ Donation 5 □ Other (Specify) Mt. Comf	ort Crem. 9-1	O~U Alexandria, VA
Ba	permit Depar Impor any in		21. Signature of Funeral Service Licensee 5	2. Name and Address of Facility Jos 130 Wisconsin Ave.	eph Gawler's Sons, Inc. N.W. Washington,DC 20016
0	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enshook, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	ter the mode of dying, such as cardiac of	or respiratory arrest, Approximate Interval Between Onset and Death
8760,	icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate and a list of the control of the cont		
O. Box 6	The law requires that the death certiticate be executed ale has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
rds, P	quires that n signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Il Records,	sician: The law requir certiticate has been si irector, page 2 should I	Completed			24a. Was an autopsy performed?  1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N
Vital	Attending Physician: r death. ector: Atter this certitics by the funeral director, 1	Be	25. Was case referred to medical examiner?	Out	n (Check only one)
	Phys this cral dir	- To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time		me 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred
O	ding I th. : Atter : funer	tlon	27. Manner of Death  1 Natural 5 Pending 2 Accident Sinvestigation  28a. Date of Injury (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	25d. Describe now injury occurred
Division of	or Dir	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or within 24 hours afte To the Funeral Dire completely tilled in the completely	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, avestigation, in my opinion, death occurr	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			V 1/1 MA	D38958	9/9/2004
	10		30. Name and address of person who completed cause of death (Item 23a) (Type Daljeet S. Sidhu, M.D. 1413 Annapol	Print) is Rd. Suite 106, (	///
	Sta Registr		31. Date filed (Month, Day, Year)  SEP 1 0 2004  32. Registrar's Signature	don V	

Physician	-	For State Ragistrar  1. Decedent's Name (First, Middle, Lague 1)	•		ertificate of		2. Date of D	Reg. No. ( eath Day	Year	3. Time of Death
/Medical		Carolyn P. Harwo					Septem Septem	ber 3,	2004	8:50 P.
Examiner		a. Facility Name (If not institution, gi	,			or Location of Death		4c. Co	unty of Death	)
		419 Russell Ave.	Apt. #309		Gaither	sburg			itgomei	су
uneral irector		083-18-4093	Sex 7. Age 1 ☐ M 2 🖾 F	(In yrs. last birtho	Months Davs		8. Date of Bi (Month, D June 2	rth ay, Year) 28,1922	9. Birth	place (State or Fore intry)
* = 1	-	Usual Residence of Decedent  10a, State 10b, County		10c. City, Town o	r Location					10d. Inside City Lim
sho in	5		1	Gaither						1 √2 Yes 2 □
be notified	2	MD Montgor  10e. Street and Number	liery	Galther	10f. Zip Code			10= Cities=	-6 18/h - 1 O - 1	
od other than "natural", or liems 23a or 28a-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director	2		4 . #200			. 7		_	of What Cou	intry ?
Azodne num Azodne num by Funerai	5	419 Russell Ave		vor in H.S.	2087		noody Voc or N	U.S.A	Race - Amer	ican Indian
Item	3	1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No		<ol> <li>Was Decedent of I If Yes, specify Cub</li> </ol>	an, Mexican, Puerto	Rican, etc.)	14.	Black, White	
, o	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	·	1 ☐ Yes 2 No	Specify:		Sp	ecify: Whi	te
atura cel E		15. Decedent's E		16a. Do	ecedent's Usual Occu	pation			of Business/I	
it, the Medical E	2	(Specify only highest gi	ade completed)	(C	ive kind of work done le. DO NOT use retire	during most of world)	king			,
E ST	5	Elementary/Secondary (0-12)	College (1-4or 5+ 4		ucator			Educ	ation	
event, Be C	2	17. Father's Name (First, Middle, Las	1)			18. Mother's Nam	e (First, Middle	a, Maiden Sui	mame)	
To B		Raymond S. Perry				Carolyn	Burdet	te		
aumatic event, the Manatic event, the Manatic event, the Manatic event the Manatic e		19a. Informant's Name/Relationship	(Type, Print)	19b. N	ailing Address (Street	and Number or Rui	al Route Numb	per, City or To	wn, State, Zi	p Code)
27 Is		Gerald Harwood -	Hughand	/ <sub>1</sub> 10	Russell A	\xxo	#200 C	nithor	ahura	MD 20877
Important: If item 27 is marke any injury or other traumatic snce.	-	20a. Method of Disposition	nuspanu		sposition (Name of crematory or other pla		Date		ion - City or T	
1: 1		1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special			crematory or other pla rn Mem. Pai		-04	Rockvi	11e. M	D
niu.	-	21. Signature of Funeral Service bics		Tarkia	22. Name and Addre	1				
any ir		De Oldan I Pa	( with	136			oseph G			
-	1	23a. Part1. Enter the disease, or con	anlications that the sed to	he death. Do not	5130 Wisco			1	gton, D	Approximate
100		shock, or heart failure. List only	one cause on each line	).	enter the mode of dy	ng, such as cardiac	or respiratory a	111631,		Interval Between Onset and Death
ician dical	1	Immediate Cause (Final disease or condition resulting in death)			ive pulmor	nary disea	ase			15 years
miner		1	Due to (or as a	consequence of):						
		Sequentially list conditions,	b	consequence of)						
nin		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 40 4	201100qu01100 01).						
ial-transit	3	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					_	
ping in										
	_		d							
Se a		IF FEMALE:	23c. If yes, outcome of	foregnancy				204	Data of dali	
for u		23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		230.	Date of deliv Month	ery Day Year
be 5		1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9☐ Unknown	ine or death	3 Unter (specify)					
£   >		Part II. Other significant conditions	contributing to death but	not resulting in th	e underlying cause on	ven in Part I.	23e, Did	tobacco use o	contribute to	the cause of death?
detached for use as the	2	·	3	•						babiy 4X]Unkno
be d										
bed y							24a. Was	OSV	prior to co	opsy findings availat impletion of cause o
2 should be c	200						1 ☐ Yes	ormed?	death? 1 ☐ Yes	2 No
page 2 should be o	and inco					26. Place of Deat	h (Check only	one)		
page 2 should be o	3	25. Was case referred to medical examiner?					ma	idence 6 🗆	Other (Speci	fy)
page 2 should be c		examiner? 1 ☐ Yes 2 ☒ No	Hospital:	t 2 ☐ ER/Outpa	tient 3 DOA	ner: 4₺ Nursing Ho	nue 2 🗆 Lez		curred	
director, page 2 should be of To Be Completed by		examiner? 1 ☐ Yes 2 ☒ No  27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)	28b. Tim	e of 28c. Inju	ry at	28d. Describe	how injury oc		
ation: To Be Completed by		examiner?  1	28a. Date of Injury (Month, Day	28b. Tim	e of 28c. Inju	ry at		how injury oc		
ne funeral director, page 2 should be cation: To Be Completed by		examiner? 1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Tim Inju	e of 28c. Inju	ry at rk?	28d. Describe		umber or Rur	al Route Number,
ne funeral director, page 2 should be cation: To Be Completed by		examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending  2 Accident investigatic  3 Suicide 6 Could not 1	28a. Date of Injury (Month, Day)	Year) 28b. Tim Inju	e of 28c. Inju	ry at rk?	28d. Describe	Street and N	umber or Rur	al Route Number,
ation: To Be Completed by		examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending  2 Accident investigatic  3 Suicide 6 Could not I determined  4 Homicide 6 Certifying P	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.  hysician: To the best of miner: On the basis of e	Year) 28b. Tim Inju y - At home, farm (Specify) my knowledge, d	e of 28c. Injury Wo 1 C	y at k?  Yes 2 □ No	28d. Describe 28f. Location ( City or To	(Street and Nown, State)	I manner as s	stated.
ne funeral director, page 2 should be o		examiner?  1	28a. Date of Injury (Month, Day)  28e. Place of Injury building, etc.	Year) 28b. Tim Inju y - At home, farm (Specify) my knowledge, d	e of 28c. Injury Wo 1 C	ny at	28d. Describe 28f. Location ( City or To	(Street and Nown, State) cause(s) and date and place	I manner as s	stated. o the cause(s)
ne funeral director, page 2 should be cation: To Be Completed by		examiner?  1	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.  hysician: To the best of miner: On the basis of e	Year) 28b. Tim Inju y - At home, farm (Specify) my knowledge, d	street, factory, office eath occurred at the tir investigation, in my of the street.	y at kt?  Yes 2 □ No	28d. Describe  28f. Location ( City or To)  and due to the red at the time,	(Street and Nown, State)  cause(s) and date and place	d manner as soce, and due to	stated. o the cause(s)  Day, Year)
ne Funeral Director. Aries in Scattilicate has been signe plately filled in by the funeral director, page 2 should be edical Certification: To Be Completed by		examiner?  1	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.  hysician: To the best of miner: On the basis of e and manner state	Year) 28b. Tim Inju y - At home, farm (Specify) my knowledge, d examination and/c ad.	eath occurred at the tir investigation, in my of the street.	y at kt?  Yes 2 □ No	28d. Describe  28f. Location ( City or To)  and due to the red at the time,	(Street and Nown, State) cause(s) and date and place	d manner as soce, and due to	stated. o the cause(s)  Day, Year)

			1 - State of Maryland / Department	artment of Health and Martificate of Death	, ,	ene . 2. 0 0 4	28805
			Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici: /Medic		Lawrence Harms		August	30 200	<sup>ar</sup> 7:45 p <sup>M</sup>
	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of D	Death
			Heritage Harbour Health & Rehab.	Annapolis		Anne	Arunde1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director	ļ	216-14-0634   180 M 2LJF   81   Yrs.   Usual Residence of Decedent		June 19	,1923 M	aryland
	and		10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	Many Fish	ō	MD Anne Arundel Annapol	is			1 ☐ Yes XXNo
	1 28e	rec	10e. Street and Number	10f. Zip Code	10	g. Citizen of What	t Country?
	death with the Maryland ma 23a or 28e-f show r must be notified at	<u>=</u>	2700 South Haven Road	21401		USA	
	deatl ma 2	Funeral Director		Vas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - A	American Indian,
o	after or Ite	F	1 🕅 Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No	i res, specify Cuban, Mexican, Pueno i I □ Yes 2X No Specify:	Rican, etc.)		Vhite, etc.
2-003a	iral'.	d by	3 Widowed 4 Divorced Year or Dates:	TET 165 222 NO Specify.		Specify:	white
ה	"natu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workin	ng 10	6b. Kind of Busine	ess/Industry
7 7	within then then	E G	Elementary/Secondary (0-12) College (1-4or 5+)	OO NOT use retired)		II D	
V	Hygie Hygie Int, II		12 Ow 17. Father's Name (First, Middle, Last)	ner 18. Mother's Name	/First Middle Ma		oat Yard
and	d be de ontal	Be c	Charles John Harms	Eva Eb		aldell Colliano,	
	should nd Me mark mati	2		ng Address (Street and Number or Rura		City or Town. Stat	te. Zio Code)
Z Z	od 2 s lith ar 17 is 27 is 1 trau	1		Crain Hwy, Upper		•	
ā,	Hea Hea tem		20a. Method of Disposition 20b. Place of Dispo	the state of the s		Oc. Location - City	
Ē	Page: ent o ent o tr: #		1 🗆 Buriai 245 Cremation 3 🗀 Hemovai from State	Crematory 9-9-2	2004 Ba	altimore	MD
Банитог	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural; or tema 23a or 28e-f show any injury or other traumatic event, the Madical Examinal must be notified at 80ce.	1	21. Signature of Funeral Service Oceasee 22	. Name and Address of Facility			
Ď	Departiment Depart		15- J. On-	Hardesty Funeral H 12 Ridgely Avenue,	lome, P.A.	A. lis. MD :	21401
			23a. Part1. Enter the disease, or complications that caused the death. Do not entreshock, or heart failure. List only one cause on each line.				Approximate Interval Between
	nysician :	d to	Immediate Cause (Final	****			Onset and Death
	/Medical		resulting in death)  a  Due to or as a consequence of):	umowi			Touy
	Examiner		Sequentially list conditions b. Almost '				/
	ν ÷	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	cate be executed physician and the burial-transit	Examine	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):				
0/00	be ex cian burial	<u>=</u>	Due to (or as a consequence or).				
0	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d				
X	death certific a attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of	dolivon
	eath atter I for u	ciar	in the past 12 months?	Ectopic pregnancy Other (specify)		Month	Day Year
<u>.</u>	that the death	isi	1 Yes 2 No 9 Unknown				
Γ.	that hed b	by Pł	Part II Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba	cco use contribut	e to the cause of death?
cords	w requires that s been signed to should be deta		Parlamon alrease		1 🗆 Yes	2 No 3	Probably 4 Mnknown
2	aw reas	ompleted			24a. Was an	24b. Were	autopsy findings available
ב	The I	E			autopsy perform 1 Yes 2	prior death	
	an: rtifica stor. p	Se C	25. Was case referred to medical	26. Place of Death			2410
>	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	t 3 DOA Other: 4 Nursing Hon	ne 5 🗆 Residen	ce 6 Other (S	Specify)
5	ng Pt fter th neral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury	28c. Injury at Work?	8d. Describe how	injury occurred	
202	endil eath. or: A the fu	catio	2 Accident investigation	M 1 Yes 2 No			
	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, strue building, etc. (Specify)	eet, factory, office 2	28f. Location (Stre City or Town,	et and Number of State)	r Rural Route Number,
ַ ב	pital uurs a eral E		00- C-15-				
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2 or	edicai	29a. Certifier  (Check only one)  Check only one)  Check only one)  Check only one)  Check only one)  Medical Examiner: On the basis of examination and/or invaning stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cau ad at the time, dat	ise(s) and manner e and place, and	r as stated. due to the cause(s)
	o the o the omple	Med	29b. Signature and title of parties.	29c. License number	290	d. Date signed (M	onth, Day, Year)
	⊢ ≯ ⊢ ŏ			D 38958			
	t.		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		1/04/14	4
	13		Datient Punch Sulle 1413	D 38958 Annufuly Read	#106	oden	tou MD21113
	Sta	ite	31. Date fited Month, Day, Year 32 Hegistrar's Signature	and a			111111
	Registr		2 SEL T NYDOA NORTH NO				

		1 - For State Registrar	State of Ma	-	partment ertificate			nd Me		giene Reg. No. [] [	9.00	28806
Physic /Medi		Decedent's Name (First, Middle, Las     ROMAN	HANAS						Date of Dea Month SEPT.	3,2004	4 <sup>Year</sup>	3. Time of Death 7:45 p M
Exami		4a. Facility Name (If not institution, give				Town, or WSOI	Location of				TIMO	RE
Funeral Director		058-26-3012	x 7. Age	(In yrs. last birthdi 78 Yrs	Months	1 Year Days	If Under 2- Hours	Min.	Month, Day	9,1926	9. Birthp Cour UK	place (State or Foreign RAINE
Aaryland f show	ō	Usual Residence of Decedent		10c. City, Town or	Location						1	0d. Inside City Limits 1 ☐ Yes <b>¾</b> ☐ <b>X</b> No
vith the Marylar or 28a-f show be notified at	Direct	10e. Street and Number		IAN	10f. Zip	Code				10g. Citizen of V		
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23e or 28e-1 show other traumatic svent, the Medical Evarinter must be routined at	by Funeral Director	8305 OLD HARF( 11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	ORD ROAD  12. Was Decedent Exammed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	ver in U.S. 1	3. Was Deced if Yes, spec	ent of Hi	234 spanic Origin, Mexican, Specify:	n? (Speci Puerto Ri	fy Yes or No- can, etc.)	U . S  14. Rac Blac  Specify	e - Americ k, White,	ean Indian, etc.
within 72 hou	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	16a. De (G	cedent's Usua ive kind of wor e. DO NOT us	k done d e retired)	uring most o			16b. Kind of Bu		
2 should be filed with and Mental Hygiene, is markad other than aumatic svant, Ing M	To Be Co	17. Father's Name (First, Middle, Last)  VERY REV. R	OMAN HAN		MICAL	LAB	18. Mother		First, Middle,	Maiden Sumam HUSLAW	ю)	
permit. Pages 1 and 2 sho Department of Health and I Important: If itam 27 is me any injury or other trauma once.		19a. Informant's Name/Relationship (7)  OLGA HANAS / WIF  20a. Method of Disposition  XXBurial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licenses	E Removal from State	20b. Place of Discemetery, of	05 OLD sposition (Nam crematory or of CHAEL	HA ne of ther place S U	RFORI KRAII	D RO Dat	AD, PA 9/8	20c. Location -	E, MC City or To ORE,	own, State  MARYLAND
rate be executed / Medical Examiner sharing and the burial-transit		23a. Par1. Enter the disease, or compshook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CFREBRO  Due to (or as a  b. Due to (or as a  c.	vascular consequence of): consequence of):								Approximate Interval Batween Onset and Death
ath certitic	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 □Ectopic pre 5 □ Other <i>(spe</i>					23d. Dat Moi	e of delive	ory Day Year
w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions co	entributing to death but	not resulting in the	e underlying ca	iuse give	n in Part I.		_	_	ribute to th 3 ☐ Prob	e cause of death?  ably 4x Unknown
sician: The law requisions contilicate has been lirector, page 2 should	Completed								24a. Was a autop: perfor 1 Yes	med?	rior to cor leath?	psy findings available inpletion of cause of
To ths Hospital or Attanding Physician: The within 24 hours after death. To the Funaral Diractor: Atter this certilicate he completely filled in by the funeral director, page	To Be	27. Manner of Death 1  Natural 5 □ Pending	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day	28b. Time		Bc. Injury Work	r: 4 🗌 Nurs	ing Home	Check only or	18)		HOSPICE
al or Attan s after deat il Diractor: id in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, (Specify)	-				f. Location (S City or Tow	treet and Numbern, State)	er or Rura	l Route Number,
ns Hospit 24 hours na Funare	edical (	29a. Certifier (Check only one) 15 Certifying Phyone) 2 Medical Exam	vsicien: To the best of iner: On the basis of e and manner state	xamination and/or	eath occurred a investigation,	at the timing op	e, date and inion, death	place, and occurred	d due to the c at the time, d	ause(s) and ma ate and place, a	nner as st and due to	ated. the cause(s)
To the Within Your Your Comp.	Me	29b. Signature and title of certifier	)w1=		29c.	License	number 372	5	2	9d. Date signed	(Month, 1	Day, Year)
V	ate	30. Name and address of person who of DR. TARIQ MAHMOOI  31. Date filed (Month, Day, Year)	•	ANEY VAI			IMONI	UM, M	D 2109	3		
Regist		SEP 1 0 2004	Pener	10 1	yours							

DHMH 17 Rev 1/2001

SEPTEMBER 3, 2004

ROMAN HANAS

			. 10000	State of Maryla	and / Dep	artme	nt of Health and	Mental Hy	giene		
			1 - For State Registrar		•		te of Death		Reg. No.	1000	28807
			Decedent's Name (First, Middle, Last	st)				2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		Dorothy	J. H	lorne					8,2004	4:13 AMM
4	Examin		4a. Fecility Name (If not institution, give				, Town, or Location of De	ath	4c.	County of Deat	
			2014 Periwinkle		rs. last birthday)		nksburg er 1 Year   If Under 24 H	rs. 8 Date of Bird	h	Carrol 9 Bid	
	Funeral Director			□ M 25XF 83	Yrs.		Days Hours Mi		y, Year) 13.1	921 Ne	hplece (State or Foreign untry) W York
			Usual Residence of Decedent					11.01		J L L I I I I I I I I I I I I I I I I I	
	arylan ehow	_	10a. State 10b. County Maryland Carroll		City, Town or Li inksbur						10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	28a-f	Director	10e. Street and Number				ip Code		10a, Citiz	zen of What Co	
:	be filed within 72 hours after death with the Maryland tal Hygiene. Ital Hygiene. do chher than "natural", or items 23a or 28a-f ehow event, Ira Medical Examinar maal be notified at	i Dir	2014 Periwinkle D	rive			21048		U.	S.A.	,
	death	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Dec	edent of Hispanic Origin? ecify Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	-	14. Race - Ame Black, White	
9	or Ite		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give		1 🗆 Yes					White
9500-61212	hours tural	ed by	15. Decedent's Ed	Year or Dates:	16a. Dece	edent's Us	ual Occupation		16b. Kir	nd of Business/	Industry
ָ בְּיִלְ	nin 72 n "na Medic	piet	(Specify only highest gra Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	life.	DO NOT	ork done during most of w use retired)	vorking			·
717	ad with giene er the	Completed	12 yr's		Но	ome M				n Home	
ב	be filed ital Hygi od other event, I	Be	17. Father's Name (First, Middle, Last, Daniel	0'Conne	11		18. Mother's N	ame (First, Middle, erine		<sub>Sumame)</sub> Morriss	ΑV
Maryland	should nd Mer marke umatic	ဥ	19a, Informant's Name/Relationship (			ina Addre					
<u>8</u>	s 1 and 2 should f Health and Mer Item 27 le marke other treumatic		Mrs. Marie A. Le	nz-Daughter	2014	4 Per	ss (Street and Number or iwinkle Driv	e Finks	burg	, MD 21	048
Š.	of Hea		20a. Method of Disposition		D. Place of Disponentery, cre	matory or	other place)	Date		cation - City or	
Ĕ	nit. Pages variment of vortent: If it injury or o		1 XBurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif		^	_	Cemetery 9/			kers, N	
Baltimore,	permit. Departr Importe any inj		21. Signature of Fineral Service Licer	Vatoch -	R I	Leona	and Address of Facility F rd J. Ruck,	Inc. 53	, ма 05 Н	ryland arford	21214 Rd.
щ	-		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the done cause on each line.	eath. Do not en	nter the mo	ode of dying, such as card	iac or respiratory a	rrest,		Approximate Interval Between
Ť	hysician		Immediate Cause (Final disease or condition	. Colm C	meir	,					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):						1
		-	Sequentially list conditions,	b. Due to (or as a cons	sequence of):						
1	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mijury that initiated events								
o`	te be executed ysicien and e burial-transit		resulting in death) Last	Due to (or as a cons	sequence of):						
		dical		d							
ox 68	ding p	/Me	IF FEMALE:	23c. If yes, outcome of pre	gnancy					23d. Date of del	ivary
Bo	death of attendation	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₹ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	□Ectopic □ Other (	pregnancy specify)			Month	Day Year
о. О	that the de led by the a detached f	hys	9 🗆 Unknown	9□ Unknown		-					_
Š,	The law requires that the death certifica te has been signed by the attending ph tage 2 should be detached for use as th	by P	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying	cause given in Part I.			-	the cause of death?
ord	requir een s hould	ted						_ 10'			· -
Records,	has b	Completed						24a. Was autor	OSV	prior to	utopsy findings available completion of cause of
			OF Was seen referred to modical				OC Place of F	perfo		1 🗆 Yes	2 No
Viital	ysiclen: is certific director,	o Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatie	ent 3 🗆 [	Othor	Death (Check only of Home 5 K Pesis		5 □Other (Spe	cify)
o	g Physer this seral di	H :	27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time	of	28c. Injury at Work?	28d. Describe			
ior	Attending I ar death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	n	,,,	М	1 ☐ Yes 2 ☐ No				
Division of	l or Atte after de Directo	Certification:	3 Suicide 6 Could not be determined		t home, farm, si ecify)	treet, facto	ory, office	28f. Location (- City or To			ural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Pi (Check only one) 2 Medical Exa	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, dea nination and/or i	ath occurre	d at the time, date and pla on, in my opinion, death of	ace, and due to the courred at the time,	cause(s) date and	and manner as I place, and due	s stated.  to the cause(s)
	To the within 2 To the complet	Med	29b. Signatura and title of certifier		<del></del>	2	9c. License number		29d. Dat	e signed (Mont	h, Day, Year)
	->-0		16 las W	ma 1-115	to	1	25443		(	7/9/	2004
	40		30. Name and address of person who	completed cause of death (	- 0 1	, Print		/		14 ~	2
	IU		John WMide	defoy 68	8 Poole	K	oad, Wes	ton in ste	1	MD	2115/
±h	Sta	ate	31. Date filed (Month, Day, Year) SFP 1 0 20	34 Registrar's Si	Si An	ode	,		-		

Waverly Gordon Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 4 - 05712State of Maryland / Department of Health and Mental Hygiene AN 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death ) 1. Decedent's Name (First, Middle, Last) Day Month Vaar **Physician** Gordon September 03, Vaveri 2004 2103 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) Yrs. 8. Date of Birth Month, Day, Yes Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 2□ F 226-20-457 Usual Residence of Deceder Director 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State show traumatic event, the Medical Examiner must be notified at Baltimore 1 Yes 2 □ No Directo 28a-f s 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Ъ 3305 St 120 Iteme 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 5 Specify: Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced natural Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within in and Mental Hygiene.
7 Is marked other than "t College (1-4or 5+) Driver Mother's Name (First, Middle, Maiden Sufname) 17. Father's Name (First, Middle, Last) Be Pear Johnson 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WIGHT JOHNSON Item 27 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: if It any Injury or o 1 □ Burial 2 □ Cremation 3 □ Removal from State 9-10-04 Owings Mills, MD \* 4 □ Donation 5 □ Other (Specify) Jaughn C Greens Funeral Snc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility augh 1 Dert d 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final · MTHENOSCIETATIO CAMO IOVASCIUM DISETASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4 Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy performed? 2 🗆 No Vital Hospital or Attending Physician: Be director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2X ER/Outpatient <sup>2</sup> 1 XYes 2 No 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; After Division 1 Natural 5 Pending investigation s after dec. 1 🗌 Yes 2 🗌 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide hin 24 hours a the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number no O.C.M.E. September 05, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOREU 111 Penn Street, Baltimore, Maryland 21201 MARYDONO

State Registrar

SFP 1 0 2004 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Alexandez 2004 6:50P. AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 2416 E.Eager Street Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last\_birthday) Birthplace (State or Foreign **Funeral** Sex 1 M 2 □ F Days Hours Min. Yrs. 580-14-1566 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow injury or other treumatic event, the Modical Examiner - ust be notified at Baltimore 1 Tes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 2416 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispar If Yes, specify Cuban, M nic Origin? (Specify Yes or No-exican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black ģ If Yes, Give Year or Dates: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician permit. Pagas 1 and 2 should be filed v Department of Health and Mental Hygie Importent: If item 27 is markad other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernara Elmina Joseph Alexander 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salters thei South Caroling 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Garrison Forest 4 □ Donation /5 □ Other (Specify) 9-10-04 VA 21. Signature of uneral S 22. Name and Address of Facility 270 Fredhilton Pass Balto, mo 21229 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician HYPEIDSCHILD FIL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dise to (or as a nonsequence of) burial-transit The law requires that the death certificate ba exacuted Due to (or as a consequence of): of Vital Records, P.O. Box 68760 physician Physician/Medical the IF FEMALE: usa 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 

Yes 2 □ No autopsy performed? 1 X Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check only one) examiner? Other: 4 \( \tag{\text{Nursing Home}} \) 5 \( \text{Residence} \) 6 \( \text{Sther} \) (Specify SCENE 1∏ Yes 2 □ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural 2 Accident Injury death, 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direc 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. AUGUST 24,2004

State Registrar

Pamela E. Szithall, 31. Date filed (Month, Day, Year)

SEP 1 0 2004

32. Registrar's Signature

30. Name and address / person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

	1	State	aryland / Depa		lealth and Me	ntal Hyg	iene	20010
		Registrar		incate of t		. Date of Deat	eg. No.	4001U
Physician /Medica	n	Decedent's Name (First, Middle, Last)  Ronald		Jones	Ś	Month CD+CM5	Day Yes	
Examine		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of D	eath
		Sinai Hospital of 1	Bultimure	Baltin	was Cit	V	NA	
Funeral Director		219-52-4532 1XM 2□F	e (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days		Date of Birth (Month, Day, 8–17–	9. 1 -50	Birthplace (State or Foreign Country)  Md.
and	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28e-1 show the Medical Exertitual is at the ricillised at	ctor	Md. NA	Balt	more				Y☐ Yes 2 ☐ No
0.2	Dire	10e. Street and Number		10f. Zip Code		11	0g. Citizen of What	Country?
238	E L	3206 Westerwald Ave.			218		USA	
or Items	Ine	11. Marital Status 12. Was Decedent Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spec an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
	۵	Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	27	Specify: I	Black
an "netural" Medical Ex	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4ors)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	durina most of working	7	16b. Kind of Busine	ss/Industry
	CO -	9th grade		ver				an Service
e 0 ≥ 1	To Be	17. Father's Name (First, Middle, Last)  Arthur	Jones		18. Mother's Name (		Maiden Sumame) Bow	den
Health and A		19a. Informant's Name/Relationship (Type, Print)  Joyce A. Williams Siste		•	and Number or Rural.d Ave., Ba			a, Zip Code) 1213
othar		20a. Method of Disposition		osition (Name of matory or other place			20c. Location - City	
nt; H i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)			9-9-0	1	Baltimore	MA
Important: If any injury or once.		21. Signature of Funeral Service Licensee	Greenmoi	2. Name and Addres			more, Md.	21202
any ir	İ	K house R Walter	c m	March F.H	I. East	1101 E	. North A	ve.
ysician Medical aminer			a consequence of):	er the mode of dyin	g, such as cardiac of	espiratory and	981,	Approximate Interval Between Onset and Death
sician and burial-transit	Examiner	cause. Enter Underlying Cause (Cissase or in jury that initiated events c	a consequence of):					
og og	edical E	d						
attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[ Yes \ 2 \] No 9 \[ Unknown \] 23c. If yes, outcome 1 \[ \] Live birth 4 \[ \] Pregnant a 9 \[ Unknown \]	2 Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>	1		23d. Date of Month	delivery Day Year
p eq	þ	Part II. Other significant conditions contributing to death to		, ,	en in Part I.			to the cause of death?
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has Je 2	Completed					24a. Was a autops perform	y prior	autopsy findings available to completion of cause of ?
certificate rector, pag	BeC	25. Was case referred to medical			26. Place of Death			
v =	2	examiner?  1 Yes 2 100 Hospital: 1 10 Hospital	ent 2 ER/Outpatie	nt 3 DOA Oth	er: 4 Nursing Hom	e 5 🗆 Reside	ence 6 Other (S	pecify)
2 = E		27. Manner of Death 1 Natural 5 Pending (Month, Da	ury 28b. Time o	of 28c. Injury World			ow injury occurred	
ath. r: Aff	atio	2 Accident investigation	, italy injury		Yes 2□No			
Diracto	Certification:	3 Suicide 6 Could not be determined 28e. Place of In building, e	jury - At home, farm, st c. (Specify)	reet, factory, office	28	f. Location (St. City or Town	reet and Number or n, State)	Rural Route Number,
	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/or in					
withir To th comp	Me	29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date signed (Me	onth, Day, Year)
0		· /hu/hu	1).0.	RES	000		Sept 7	2004
5		30. Name and address of person who completed cause of Kerin Hayes D.O.	2401	Print) WEST	Belvede	re Av	< Balta	max mo 2121.
Stat Registra		31. Date filed (Month, Day, Year) 32. Refist	rar's Signature	hack )				
MH 17 Rev 1/20		JL1 2 0 2007 JOG	- N. J.					

		1 - For State Registrar	State of Marylan	d / Depa		lealth and M		ne 2001.	28811
Physic /Med Exam	ical	4a. Facility Name (If not institution, give	Jennings			r Location of Death	2. Date of Death	Day Year ZUO 4c. County of De	1 3-29 +
Funera Directo		5. Social Security Number 6. Se	7. Age (In yrs.)	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Jan. 4, 1		nthplece (State or Foreig Country) th Carolina
the Maryla 28a-f shov	ector	Maryland  10e. Street and Number		y.Town or Lo	2				10d. Inside City Limits 1 X Yes 2 □ No
th with 23a or	al Dir	3611 East Norther	n Parkway		10f. Zip Code 21206			Citizen of What C	ountry?
ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23a or 28a-f show or other traumatic event, the Medical Event ar must be trained.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☒ No	lispanic Origin? (Spe an, Mexican, Puerto f Specify:		14. Race - Am Black, Wh Specify: Wh	ite, etc.
ad within 72 hours aft glene. er then "naturel", or	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give life.		ation during most of workir f)	ng	Kind of Busines:	
war y latta Z I z d 2 should be filed with th and Mental Hygiene, 27 Is marked other the traumatic event, then	To Be Co	12 17. Father's Name (First, Middle, Last) Charles Marshall	Pender	Nu	rsing	18. Mother's Name Willie I	(First, Middle, Maid	Hospital en Sumame)	1,
C, Mal)  1 and 2 sho Health and N em 27 Is me		19a. Informant's Name/Relationship (7) William E. Jenni: 20a. Method of Disposition	ngs (Son)	374 E	lidden Va	and Number or Rural	Wythevil:	Le, VA 2	4382
t. Pa		1  Burial 2  Cremation 3  ☐   1  Donation 5  Other (Specify, 21. Signature of Funeral Service Libens	Ove	rlook	sition (Name of natory or other place Cemetery	9/4/0	)4 I	Eden, NC	Town, State
Depa Impo		XILLEUI.W	Velally		Fair Fune	ss of Facility eral Home e Road, Ec	len. NC 27	7288	
ate be executed  Wedical hysician and he burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Λ	elogen renca of):	A	ukemia	respiratory arrest,		Approximate Interval Between Onset and Death
death certific e attending pl	Physician/Medical	IF FEMALE:	d	death 3	Ectopic pregnancy Other (specify)	-		23d. Date of de Month	ivery Day Year
The law requires that the law requires that the law been signed by the lagge 2 should be detached.	by	Part II. Other significant conditions co	ntributing to death but not resu	lting in the un	derlying cause give	en in Part I.	23e. Did tobacco		the cause of death?
	e Completed	25. Was case referred to medical					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of 200000
. × × × × × × × × × × × × × × × × × × ×	n: To B	examiner? 1  Yes 2 No  27. Manner of Death	28a. Date of Injury	R/Outpatient 28b. Time of	28c. Injury	at 28	e 5 Residence		cify)
f or Attending after death. Director: After	ertification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day Year)  28e. Place of Injury - At hor building, etc. (Specify)	Injury ne, farm, stre		? ′es 2 □ No	8f. Location (Street a	and Number or Ru	ıral Route Number,
To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Cer	29a. Certifier 1 Certifying Phy. (Check only 2 Medical Exemi	sician: To the best of my knowner: On the basis of examination	dedne death	occurred at the time	e, date and place, an	City or Town, Sta	a) and manner as	stated.
To the within 2 To the complete	Med	29b. Signature and title of certifies	and manner stated.		29c. License			ate signed (Monti	
		30. Name and address of person who co	empfeted cause of death (Item			251	Hvai	IST 31	2004
5 Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	Orter	e Street	Baltimo	re, MD	21201	
Regist	rar	SEP I 0 20	04 Genera	4	100				

		•	For State Registrar		St	tate of	Marylan				lealth a		ental Hy	giene Reg. No.	004	28812
	Physicia		1. Decedent's Nam France	ne (First, Middle, es Kasper	Last)								2. Date of De.	ath Pay	2004	3. Time of Death 7. \( \to \mathcal{P} \) M
	/Medic Examin	_	4a. Facility Name (	(If pot institution, HCG (f hC	give stree	900	Catos A		BS	Him	r Location	141	)		N/A	
P	Funeral Director		5. Social Security 1 217–30–37.	12	5. Sex 1 ☐ M		'. Age (In yrs. I	ast birthday) Yrs.	Months Months	Days	If Under Hours	Min.	8. Date of Bird (Month, Da July 16	y, Year) 5, 1918	Col	nplace (Stete or Foreign untry) aryland
	the Maryland 28a-f show notified at	tor	Usuel Residence of 10a. State MD	10b. County		N/A	10c. City	, Town or Lo	ocation			:	Baltimore	e City		10d. Inside City Limits 13€Yes 2 □ No
	death with the Maryland ms 23s or 28s-f show rmust be notified at	i Director	10e. Street and No.	umber Benson Ave	enue				10f. Zij	Code	212	230		10g. Citize	n of What Cor	untry?
D07 036		by Funerai		rried 2 Marrie	ed 1	Was Deced Armed For I Yes If Yes, Give Year or Da	2 <b>X</b> No	S. 13.	Was Dece If Yes, spe	city Cuba	dispanic Or an, Mexica Specify:	n, Puerto	ecify Yes or No Rican, etc.)		Race - Amer Black, White becify: Wh	e, etc.
1215-0	within 72 hours after ane. than "natural", or Ite	Completed	(Spe	15. Decedent' ecify only highest condary (0-12)	grade coi		4or 5+)	(Give	DO NOT L	rk done se retired	during mos d)	st of worki	ing	16b. Kind	of Business/I	
CCS land 2	be filed tal Hygid d other	To Be Co	17. Father's Name	(First, Middle, L Joseph R.		r			Sē	lespe			(First, Middle,		umame)	
Mary	and 2 should salth and Men n 27 is marke ier traumatic		19a. Informant's N Yvonne Te			Print)							nore MD 2	-	own, State, Z	(ip Code)
₹ Baltimore,	permit. Pages 1 and Department of Health Important: if Item 27 any injury or other tr ones.			sposition  Cremation  Control  Cremation		oval from S		lace of Disponentery, cre	matory or i	other plac	sept		11, 200		tion · City or 1	Town, State ore Maryland
Balti	permit. Pag Department Importent: I any injury o once.		21 Signature of E	uneral Service L	icensee	Victor	P. Doda		harles	L. S	ss of Facili	Fune	ral Home, Baltimore	Inc.	230	
8760,	Medical Examiner be executed by Natician and sthe purial-transit the purial-transit	dical Examiner	23a. Pert1. Enter shock, or he Immediate Cause disease or conditions of the conditions of the cause. Enter Uncause. Enter Uncause Chisasse of that initiated even resulting in death)	eart failure. List of (Final ion )  conditions, immediate derlying or injury its	a. b. — c	Due to (c	or as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a con	uence of):	2PS1	pik S is	a to	1	Sf	rrest,		Approximate Interval Between Onset and Death
P.O. Box 6	that the death certificated by the attending plucetached for use as the	Physician/Medical	IF FEMALE: 23b. Was decede in the past 1. 1 ☐ Yes 2 9 ☐ Unknow	2 months?		1 Live bi	come of pregna rth 2 Fetal ant at time of down	I death 3[	⊒Ectopic p ⊒ Other (s		у			236	d. Date of deli Month	ivery Day Year
	requires that the been signed by should be detact	b	Part II. Dther sign	nificant conditio	ns contrib	uting to de	ath but not res	ulting in the a	nderlying	cause giv	ven in Part	l. 		obacco use Yes 2 🗀		the cause of death?
al Reco	iician: The law requi certificate has been rector, page 2 should	Completed				O'							1 Yes	osy rmed? 2 V No	prior to death?	topsy findings available completion of cause of
Division of Vital Records.	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	cation; To Be	25. Was case referexaminer?  1 Yes 2 2  27. Manner of Dea 1 Natural 2 Accident	No ath 5 ☐ Pending investig	ation	14 <b>S</b> 1Ir	npatient 2  If Injury h, Day Year)	ER/Outpatie 28b. Time o Injury		28c. Injui Wo	ner: 4□N	ursing Ho	n (Check only on me 5 ☐ Resident Section 128d. Describe 1	dence 6 [ how injury o	occurred	
Divis	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 □ Co <i>u</i> id r determi	ned 2	28e. Place buildir	of Injury - At ho ag, etc. (Specif	ome, farm, st	reet, facto	y, office			28f. Location (. City or Tot		Number or Ru	ıral Route Number,
	the Hosp in 24 hou the Fune ipletely fil	ledical	29a. Certifier (Check only one)	2 Medical	g Physicia xa ninei:	On the ba and mann	sis of examina	wledge, dea tion and/or ii	rvestigatio	n, in my o	opinion, de	nd place, ath occurr	and due to the ed at the time,	date and p	ace, and due	to the cause(s)
	With Con	Σ	29b. Signarure	d title of certifier	who	MO			1	100	S56	25		00	signed (Month	-
_	12		Royce	dress of person		o Ci	970N /	NE	Print)	LTIA	10RE	HD	2122	9		1
	Sta Regist		31. Date filed (Mo	onth, Day, Year)	004	32. R	egistrar's Signa	iture								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death **Physician** 3:45 DM /Medical 4a. Facility Name (If not institution, give street Examiner 4b. City, Town, or Location of Death 4c. County of Death VILLA NOVA Social Security Number 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) Months Days Year) 1 M 2 F Hours Min. Director Yrs "JJ Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exams ar must be notified at 10d. Inside City Limits Director Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced BIACK 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Callege (1-4or 5+) (0-12)Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Brown 's Name/Relationship (Type, Print) 19b. Mailing Address (Stree, and Number permit. Pages 1 and 2 sh Department of Health and Important: if Item 27 is m any injury or other traum <u>once.</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kandallatorun, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 12 /Medical Due to for as a consequence of): Examiner Sequentially list conditions, ause. Enter Underlying Cause (Disease or injury that initiated events (phas a nonsaquence lot) Examiner use as the burial-transit 1 h 21 resulting in death) Last Due to (or as a con equence of) Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy ō Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig 2 🗆 No 3 Probably 4 ₩mknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 🗹 No director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 SHatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by it 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 \ Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. the Hospital or Attending Physician:

attending physician

the a

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certificate

his

After

Director:

death.

with the Maryland

death

d 2 should be filed within 7: h and Mental Hygiene. 7 is marked other than "ni

Baltimore, Maryland 21215-0036

Registrar

5

31. Date filed (Month, Day, Year) 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cancuph

29b Signature and title of certifier

40 200 Registrar's Signature 29c. License number

4680

5+ # 136

29d. Date signed (Month, Day, Year)

-			1 - For State Registrar	State of Marylan	•	artment of h		-	giene Reg. Nø? (		28811
-	Physici		1. Decedent's Name (First, Middle, Last)	KNACK	181			2. Date of De SEPTER	ath Day	6 Year	3. Time of Death
}	/Medic Examir		4a. Facility Name (If not institution, give to NORTHWEST H	street and number) OSPITAL CE	MIER	4b. City, Town, o	TLLS TO			unty of Death	
	Funeral Director		LI 1 00 33L3	7. Age (In yrs. 96	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Ain. 8. Date of Bin September	<sup>th</sup> 23, 1	907 Mary	ace (State or Foreign Mand
	ryland how		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo					10	d. Inside City Limits
	the Ma 28a-1 s	ector	Maryland Baltimore  10e. Street and Number		Lochear	10f. Zip Code			10a Citizan	of What Count	1 ☐ Yes 2 No
	th with	al Dir	6811 Campfield Road			2120	7		-	SA	ıy?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examinar roual be notified at ance.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ★ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	'	Was Decedent of H f Yes, specify Cub	an, Mexican, Pu	(Specify Yes or No uerto Rican, etc.)		Race - America Black, White, e ecify: White	
21215-0036	within 72 h lene. than "natu ne Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) Unknown	cation e <i>completed)</i> College (1-4or 5+)	(Give	lent's Usual Occup kind of work done DO NOT use retire es Person	oation during most of d)	working		of Business/Ind Company	ustry
Maryland 2	ould be filed Mental Hyg erked other etic event,	To Be C	17. Father's Name (First, Middle, Last)  Jacob Gerbig				18. Mother's I	Name (First, Middle,	Maiden Sui Mueller		
Mar	od 2 sho lith and 27 is m		19a. Informant's Name/Relationship (Ty Augsburg Lutheran Home			-		Rural Route Number			Code) 21207
Baltimore,	bages 1 ar ent of Hea nt: If Item 3		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ P  4 ☐ Donation 5 ☐ Other (Specify)	20b. F	Place of Dispo	sition (Name of natory or other plan Faith Cem.	cal	Date 10,2004	20c. Locati	on - City or Tov	vn, State
Balti	permit. I Departm Importer any inju		21. Signature of Funeral Service License	Christina L. Hi L. Wilton	16	Name and Address Onard J. R	uck, Inc.	altimore Mar	vland	21214	
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the deat ne cause on each line. a	h. Do not ent	er the mode of dyir					Approximate Interval Between Onset and Death
	Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (In as a conseq							
8760,	icate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
P.O. Box 68	The law requires that the death certificate the seen signed by the attending phy page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 prioriths? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ıl death 3 □	Ectopic pregnancy	у		23d.	Date of deliver Month	y Day Year
	quires that I in signed by uld be deta	ρ	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the ur	nderlying cause gre	ven in Part I.	23e. Did to	1/	_	e cause of death?
Il Records,	The law requirate has been sipage 2 should l	Completed						24a. Was autop perfor 1  Yes	sy	4b. Were autop prior to com death? 1 \( \sum Yes \( 2 \)	sy findings available pletion of cause of
of Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	ER/Outpatien	Oth	100	Death (Check only o		0.1 /0 /4	
ion of		atlon; To	27. Marner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	ry at	g Home 5 🗌 Resid 28d. Describe h			
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Nu n, State)	umber or Rural	Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Physical (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ition and/or inv	occurred at the tir restigation, in my o	me, date and pla ppinion, death o	ace, and due to the occurred at the time,	cause(s) and date and pla	d manner as sta ce, and due to	ted. the cause(s)
	To the within To the complex	Me	29b. Signature and title of certifier	PHYSICI	AN.	29c. Licens	ta7a			ned (Month, D	•
			30. Name and address of person who co	empleted cause of death (Item		Print) No	RTHU	LA CON	HOSPI R	TAL	CENTER MD 21133
	Sta		31. Date filed (Month SEP Year) 0 20	32. Pegistrar's Signa	ature	6.1.					

			1 - For State of Maryland /	Depa	artment of Health and Martificate of Death	ental Hygi		28815
		7g.	Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici **/Media		LENA MARCELLA KRUG			SEPT. 5,	Day Year 2004	1 AM
<b>)</b> .	Examir	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Deat	1
70			315 FOLCROFT STREET  5. Social Security Number 6. Sex 7. Age (In yrs. last t	hirthday	BALTIMORE  If Under 1 Year   If Under 24 Hrs.	9 Date of Birth	N/A	
	Funeral Director		220-03-3580 1 M 2 T	Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, JAN. 20,	Year) 9. Birti Co.	oplace (State or Foreign untry) MD .
	yland		10a. State 10b. County 10c. City, To	wn or Lo	cation			10d. Inside City Limits
	B Mar	ctor	MD. N/A	BALT	IMORE			1 XYes 2 No
	72 hours after death with the Maryland netural', or Itams 23s or 28s-1 show deat Executes to notified at	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Co	untry?
	s 236	eral	315 FOLCROFT STREET	10	21224	7 37 11	U.S.A.	
"	fter d	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes 2 ☐ No	13.	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto I X	City Yes or No- Rican, etc.)	14. Race - Amer Black, White	
036	al', o	by	3		I ☐ Yes 2 ☐ No Specify:		Specify: W	HITE
21215-0036	72 hc	Completed	15. Decedent's Education 16 (Specify only highest grade completed)	(Give	lent's Usual Occupation kind of work done during most of working	10	6b. Kind of Business/I	ndustry
121	within iene. than "	mpl	Elementary/Secondary (0-12) College (1-4or 5+) 6TH	life.	OONOT use retired)  CASHIER		DALETMODE	OTTIV
	fillad Hyg thei		17. Father's Name (First, Middle, Last)		18. Mother's Name		BALTIMORE	CITY
Maryland	Mental Aurked o	To Be	FRANK O'CONNOR			AMILTON	aden Sumame,	
ary	2 should be and Menta Is marked sumatic so	-		b. Mailir	g Address (Street and Number or Rura		City or Town, State, Z	ip Code)
	27 It		PAT FENDRYK/DAUGHTER		HORNEL STREET, BA		-	
ore,	gas 1 an of Heal If itam 2 or other		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State	of Dispo			Oc. Location - City or 1	
Ĕ	Pag ment ant:		'4 □Donation 5 □Other (Specify) OAK L	AWN	CEMETERY 9/8/	04	BALTIMORE,	MARYLAND
Baltimore,	permit. Pag Deportment Importent: any njury c		21. Single of Funeral Service Licensee		. Name and Address of Facility CH 6224 EASTERN AVE.,		ZEILER & RE, MARYLA	
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or beart failure. List only one cause on each line.	not ent	er the mode of dying, such as cardiac or	r respiratory arres	it,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	112	Ischemic CAR	dea ma	0001/4	Onset and Death
	/Medical Examiner					, ,	, ,	0
		ia G	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	e of):	30			> 25 years
	uted d ansit	m.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		mellitus			> 254 wy
oʻ	te ba exacuted ysician and e burial-transit	Examiner	resulting in death) Last  Due to (or as a consequence		· · spri · più			- /
8760	cate ba physicia the bu	cal	d					
9	artifica ing ph e as th	Physician/Med	IF FEMALE:					
Вох	law requires that the death cartific as been signed by the attending p 2 should be detached for use as it.	lan/	23b. Was decedent pregnant in the past 12 monwars? 1 ☐ Live birth 2 ☐ Fetal dea:		Ectopic pregnancy		23d. Date of deliv	very Day Year
0	at the de by the a tached f	yslc	1 ☐ Yes 2 No 4☐ Pregnant at time of death 9☐ Unknown	5	Other (specify)		, worth	Day Four
Δ.	res that t igned by be detad		Part II. Other significant conditions contributing to death but not resulting	in the ur	iderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds	puires n sign ald be	d by	it goes tousind			1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
Vital Records,	aw require ts been si 2 should b	Completed	caratid Vascular			24a. Was an	24b. Were aut	opsy findings available
Re	9 4 96	шо	<i>V</i>			autopsy performe	death?	ompletion of cause of
ita		BeC	25. Was case referred to medical examiner?		26. Place of Death			20 140
of V	Physician: this certific ral director,	P C	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/C			ne 5 nesidend	ce 6 ☐Other (Speci	fy)
n c	ding P h. After t funera	lon:	1 ☑Natural 5 ☐ Pending (Month, Day Year)	. Time of Injury	Work?	8d. Describe how	injury occurred	
Division	Attending r death. actor: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	form at-	M 1 Yes 2 No	96 Leasting /Stra	at and Number of Co.	-1 O M
Di≤	Dir	ertif	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	ann, sue	eet, factory, office	City or Town,	et and Number or Rur State)	al Houte Number,
	To the Hospital or within 24 hours after To the Funeral Dii completely filled in		29a. Certifier 12 Certifying Physician: To the best of my knowledge	ge, death	occurred at the time, date and place, a	nd due to the cau	se(s) and manner as	stated
	the Ho nin 24 h the Fu npletely	edical	(Check only 2 Medical Examiner: On the basis of examination a and manner stated.	nd/or inv	estigation, in my opinion, death occurre	d at the time, date	e and place, and due t	o the cause(s)
	To the comp	Σ	29b. Signature and title of certifier		29c. License number	-	I. Date signed (Month,	* * * * * * * * * * * * * * * * * * * *
	7		Jehl/Knobe no		DO 1889	9	-7-04	
	8		30. Name and address of person who completed cause of death (Item 23a	(Type,	Print)		1/	
			31 Date filed (Month, Day, Year) 32 Begistrar's Signature	1145	BUGUISW CIA	isal	timore	MID ZIZZY
	Sta Registr		31. Date filed (Month, Day, Year) 2004 32/ Registrar's Signature	4	DO 1889 Bagusa Cin			

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Dete of Death 1. Decedent's Neme (First, Middle, Last) :15 PM 4b. City. Town, or Location of Deeth 4c. County of Death, Fecility Neme (If not institution, give street end number) nesis Kandallstown Ctr. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex Days Hours 1□M 200 F MD 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Dyes 2 □ No attimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 21215 Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) tary/Secondary (0-12) College 18. Mother's Name (First, Middle, Maidei Informant's Name/Relationship 19b. Mailing Address (Street and Number 20b. Place of Disposition (Name of cometery, crematory or other place) Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltimore MD Greene Funeral Snc 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Fecility 1 21. Signature of Funeral Service Licensee malbtown MD 21133 Approximate Interval Between Onset and Death 23a. Pert1. Enter the dispese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 Inpatient 4 Nersing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

25. Was case referred to medical examiner? 1 Tes 27. Manner of Death Waturel 2 Accident 3 ☐ Suicide 4 Homicide critifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier

29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie

NU

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

31. Date filed (Month, Day, Yeer) 32. Registrar's Signeture



**DHMH 16 Rev 6/95** 

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funerel di

To the Hospital or within 24 hours at To the Funeral D

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**Physician** /Medical

Examiner

Funeral Director

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Be

**Funeral** 

Director

Peges 1 and 2 should be filed within 72 hours efter daath with the Marylend

Baltimore, Maryland 21215-0020

item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examinar must be notified at

parmit. Peges 1 and 2 should be filed with Department of Health and Mentel Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the MORE.

**Physician** 

Attending Physician: The lew requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

/Medical Examiner

Physician/Medical

Be Completed by

Medical Certification: To

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 8, 2004 **Physician** Shirley Louise 1:25P LeMaitre /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 🗶 Months 084-12-9834 82 Director Massachusetts August 2.1922 Usual Residence of Decedent 10b. County 10c. City. Town or Location 7 le marked other than "natural", or Itema 23a or 28a-f ehow traumatic event. It a Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2√No Maryland Baltimore Baltimore Funeral Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1111 Overbrook Road 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2A No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes > No Specify: White Specify: 3XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed with and Mental Hygier 7 te marked other tt Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Graham Barbara Ellsworth Richardson George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2...
Department of Health ar Important: If item 27 le any injury or other trau 1111 Overbrook Road Baltimore, Maryland 21239 Linda B Clarke DTR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) Greenmount Cemetery 19/9/04 Baltimore, Maryland gnature of Funeral Sey 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician MYOCADIAL /Medical Due to (or as a consequence of) Examiner Womans astery Sequentially list conditions, if any, learning to limite diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performag! 24b. Were autopsy findings available prior to completion of cause of death? 2 A No 1 ☐ Yes 2 ☐ No 1 Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📆 🕏 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Hospice 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Division To the Hospital or Attending 5 Pending 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0, eause of death (Item 23a) (Type, Print) 30. Name and address of person 6601 N. Charles Street Towson, Md. 21204 Pa0 2004 32. Registrar's Signature State Registrar

			1 - State Registrar	State of Maryl		artment of rtificate of			jiene •a. №.∩ £	11 6	00010
	Physici /Medic		Decedent's Name (First, Middle, Last     John	Robert		Leonard		2. Date of Dea Month Septem	th Day	Year 2004	3. Time of Death
	Examir		4a. Facility Name (If not institution, give Anne Arundel Medi			Annap			4c. Count	y of Death nne Ar	
	Funeral Director		5. Social Security Number 6. Se 143-24-6838  Usual Residence of Decedent	7. Age (In ) MM 2 F 76	yrs. last birthday) Yrs.	If Under 1 Yea Months Days			<sup>Year)</sup> 1928	Coun	lace (State or Foreign try) York
	th the Maryland or 28a-f show e notified at	Director	10a. State 10b. County  MD Anne Art  10a. Street and Number		City, Town or Lo			1	0g. Citizen of		0d. Inside City Limits 1 ☐ Yes 2√√No try?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23e or 28e-f ahow any injury or other traumatic avant. If a Medical Evantmer must be notified at 2008.	oy Funeral D	9 Wainwright Aver  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ∑ Yes 2 ☐ No If Yes. Give		2140 Was Decedent of If Yes, specify Cu 1 □ Yes 2▼ No	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ce - Americ ack, White, e	
21215-0036	ad within 72 hou giene. er than "natura er the Medical E.	Completed by Funeral	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation	16a. Deced	dent's Usual Occu kind of work done DO NOT use retin	during most of y	working	16b. Kind of E	Business/Ind	lustry
Maryland	2 should be filed within and Mental Hygiene. Is markad other than sumatic avant, Ita Me	To Be (	17. Father's Name (First, Middle, Last)  John Robert Leona  19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Stree	Helen	Name (First, Middle, I Murphy Rural Route Number			Code)
Baltimore, M	Pages 1 and 2 nent of Health snt: If item 27 i		Marianne J. Leona  20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	201 Removal from State	b. Place of Dispo	sition (Name of natory or other pla	ace)		MD 2 20c. Location	- City or To	
Balti	permit. Page Department Important; if any injury o		21. Signature of Funeral Service Licens			Name and Addr Hardesty	ess of Facility Funera	1 Home, P. ue, Annapo	Α.		
THE REAL PROPERTY.	Pnysician /Medical Examiner	ler	23a. Pant1. Enter lhe disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ications that caused the dine cause on each line.  a	sequence of):			iac or respiratory arre			Approximate Interval Between Onset and Death AOUTS WWONTHS
68760,	ificate be executed g physician and as the burial-transit	edicai Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):						
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ords, P	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions cor	ntributing to death but not	resulting in the ur	nderlying cause gr	ven in Part I.				cause of death?
of Vital Records,	The ate h page	e Completed	25. Was case referred to medical						red?	prior to com death?	sy findings available pletion of cause of
	hys his I dii	ToB	examiner?	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	her: 4 \(\sum \) Nursing	eath (Check only one Home 5 Reside 28d. Describe ho	nce 6 Oth		
Division	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	ecify)			28f. Location (Str. City or Town	State)		
	tha Hosp thin 24 hou the Fune impletely fil	Medical	one)	sician: To the best of my kiner: On the basis of examend manner stated.	mation and/or inv	occurred at the trestigation, in my	opinion, death oc	curred at the time, da	te and place,	and due to t	he cause(s)
•	F 3 F 8		30. Name and address of perspn who co	moleted cause of death (I	tem 23a) (Type I	D i	16052			10 4	ay, rear)
	Sta	e	31. Date filed (Month. Day, Year)	4, MD 200	1 Medica	al Pouhw	ay and	natolis, ty	0		
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			For State Registrar	State of Ma		epartment of F Certificate of		lental Hygie	2001	28819
ı	Physici /Medic		1. Decedent's Name (First, Middle BERNARD	, Last)	LUKE	nich		2. Date of Death SEPT.	Day Year 200	3. Time of Death  3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution  Loch Row  5. Social Security Number  219–16–8915	en Nursii	yrs. last birt	ne Bai	or Location of Death    If Under 24 Hrs.     Hours   Min.	8. Date of Birth (Month, Day, Ye 10/20/19:		thplace (State or Foreign
			Usual Residence of Decedent 10a. State 10b. County		10c. City, Town			10/20/19	23   Ma	10d. Inside City Limits
	th the Ma or 28a-f s	)irector	MD Balti  10e. Street and Number	more	Rose	dale 10f. Zip Code		10g.	Citizen of What Co	1 ☐ Yes 2 🙀 No puntry?
136	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28e-f show ha Modical Examirer must be notified at	by Funeral Director	8132 Old Phil  11. Marital Status  1 Never Married 2 Marri  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces?	Ever in U.S.	21237  13. Was Decedent of Hilf Yes, specify Cuba	dispanic Origin? (Spe an, Mexican, Puerto I Specify:	ocify Yes or No- Rican, etc.)	U.S.A.  14. Race - Ame Black, Whit	
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and z	be filed tal Hygi d other event, I	Be	12 17. Father's Name (First, Middle, George Lukeni	·		Supervisor		(First, Middle, Maid ne Korkey		
Baitimore, Maryland	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked eny injury or other treumetic engo.e.	То	19a. Informant's Name/Relationsl  Carol Fischer  20a. Method of Disposition 1 ☎ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)  21. Signatur of Fune/al Service	ip (Type, Print)  /Daughter  3     Removal from State necity)	20b. Place of cemeter	Mailing Address (Street  32 Old Phil Disposition (Name of A, crematory or other place  Son Forest  22. Name and Addre  6415 Belai	and Number or Rura Ladelphia ce) 9/11 ss of Facility Mil	Road Balt ate 20c /04 B	y or Town, State, A imore M Location - City or altimore 1 Funera	aryland Town, State , Maryland 1 Home Inc.
g/pn,	bhysician and physician and physician and physician and street is the burial-transit	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (	a. Arai Due to (or as a b. Due to (or as a c.		ot enter the mode of dying Arry Hims  f):  f):	ng, such as cardiac o		-ury rund	Approximate Interval Between Onset and Death
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ras, P.	w requires that the de been signed by the a should be detached t	by	Part II. Other significant condition	ns contributing to death bu	ut not resulting in	the underlying cause giv	en in Part I.	23e. Did tobacc	_	the cause of death?
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VISION OT VITE	Phys this al di	ertification: To Be	25. Was case referred to medical examiner?  1  Yes  2  Vo  27. Manner of Death  1  Natural  5  Pending investig 3  Suicide  6  Could n	ation	y 28b. T Year) In	me of 28c. Injury World 1	4 No Nursing Hom y at 2 k? Yes 2 □ No	ne 5 Residence	jury occurred	
N	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	al Certif	4 Homicide determi		. (Specify)	m, street, factory, office		28f. Location (Street City or Town, St.	ate)	
	o the Hos ithin 24 h o the Fun ompletely	Medica	(Check only one)  2 Medical I	xaminer: On the basis of and manner sta	examination and	Vor investigation, in my o	pinion, death occurre	ed at the time, date a	(s) and manner as and place, and due  Date signed (Monti	to the cause(s)
	1X		> Grighen	Gas, mi	>	8	88755		nt. 07	,2004
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NOWN 04-298	State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental State of Maryland / Department of Health / Department / D	ental Hygiene	1001 00000
Physician		2. Date of Death Month Day	3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death UNIVERSITY HOSPITAL BALTIMORE CITY	SEPT. 5,	2004 12:46A TOURLY OF Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min.  Usual Residence of Decedent	8. Date of Birth Month, Day, Year)	9. Birthplace (State or Foreign Country)
ith the Maryland or 28a-f show on utilitied at	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Sitter death with the Mainter death with the Mainter rust be nutified in a function.	10e. Street and Number 2554 W. BATIMORE 97. 2123	10g. Citiz	zen of What Country?
5-0036 72 hours after death with the Maryland natural; or Itams 23a or 28a-f show dies! Examinat the multified at steed by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	g 16b. Kir	nd of Business/Industry
yland 212  Juld be filed with Mental Hygiene.  arkad other than atic avant, tre N To Be Comp	17. Father's Name (First, Middle, Last)  18. Mother's Name (Part of the Company o	(First, Middle, Maiden	Surname)
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Baltimore, M permit. Pages 1 and: Department of Health Important: If item 27 any injury or other tr	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  4 Donation 5 Other (Specify)	10 20c, Lou	cation - City or Town, State
Baltim permit. Pag Department Important: any injury c	21. Signature of Juneral Service Licepsee  22. Name and materials and ma	HALBRAL HAL	min 127 TMD 21229
Physician	23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or read failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. White blunt face in the sand asphyxic resulting in death)		Approximate Interval Between Onset and Death
/Medical Examiner ট	Due to (or as a consequence of):		
oertificate be executed rding physician and use as the burial-transit	Sequentially list conditions, if any, leading to limited and a consequence of lice ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):		
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eCords, P.O. Bc law requires that the death as been signed by the atter 2 should be detached for u pleted by Physiciar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !,		se contribute to the cause of death?
II Records, The law requires the cate has been signe page 2 should be completed by		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 → Yes 2 → No
on of Vital R ding Physician: The h. Atter this certificate h tuneral director, page	25. Was case referred to medical examiner?  1 XYes 2 No		□Other (Specify)
DIVISION O Pospital or Attanding Pt 24 hours after death. a Funaral Diractor: After it etely filled in by the funeral dical Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28	If. Location (Street and	-assaultee) Number or Rural Route Number.
Hospi 4 hou Funai ely fil	29a. Certifier (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the cause(s)	and manner as stated.
Within 2 To tha I To tha I complet	one) and manner stated.  29b. Signature and title of certifier 29c. License number	29d. Date	signed (Month, Day, Year)
	Jaska of theenberg up O.C.M.E	SE	EPT. 5, 2004
4	30. Name and address of person who completed cause of death (flem 23a) (Type, Print)		
State Registrar	31. Date filed (Month, Day, Year) SEP 1 0 200  32. Registrar's Signature SEP 1 0 200	Maryland	1 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) MO **Physician** /Medical 4c. County ol Death 4b. City, Jown, or Location of Death **Examiner** (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Country) **Funeral** Months Min. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f ahow any injury or other traumatic event. If we Menter Itams 23a or 28a-f ahow 10b. County 10c. City. Jown or Location 10d. Inside City Limits 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during like. BQ NOT use retired) 16b. Kind of Business/Industry during most of working College (1-4or 6+) MO21133 196. Mailing Address (Street and Number or Rural A dethod of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State • 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee odallstum. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. App ximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Severe Priysician 155. /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate the Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. Il yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed's 2 1 No 1 Yes 2 🗆 No 1 Yes Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 | Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Diractor: A completely filled in by the fu death. 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) D-0012849

State Registrar 31. Date filed (Month, Day, Year)

m

7600

2. Registrar's Signature

OSLER DY. TOWSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 0 2004

			for State Registrar	State of Maryland / D	Department of Health  Certificate of Deatl		jiene	28822
	Physici /Medio	cal	1. Decedent's Name (First, Middle, Las  DORA 5  4a. Facility Name (If not institution, give	PARSHALL	4b. City, Town, or Location	2. Date of Dea		3. Time of Death 9:30 At M
	Examir Funeral Director	ier	1201 BLACK F. 5. Social Security Number 6. Se	XARS RV x 7. Age (In yrs, last bir	CATONGUI	or 24 Hrs. 8. Date of Birth	BALTIM	DRE place (State or Foreign place)
	e Maryland a-f show	ctor	10a. State  10b. County  Galtim	ore Caton	or Location SU IIC		1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No ,
	h with the	Funeral Director	1201 Black Frian		10f. Zip Code 2/228		Og. Citizen of What Coun	itry?
920	ours after deal ral', or items : Examinar mu	by	11. Marital Status  1 ☐ Neyer Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1  Yes 2 No Specify		14. Race - Americ Black, White, Specify: Black	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examinational angance.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during mo- life. DO NOT use retired) CCIAL WORKER		16b. Kind of Business/Ind	lustry
yland	should be fill ind Mental H s marked oth umatic even	To Be	James Slater	·	Rel	her's Name (First, Middle, OPCCO Gri	Maiden Surhame) Ffin	
	1 and 2 sho Health and am 27 is mu ther traumi		19a. Informant's Name/Relationship (7)	15 - daughter 3:	Mailing Address (Street and Num. RIS Blur Nill Rd	ber or Rural Route Number  Baltimore  Date	MD 2120	7
altimore,	Pages tment of h tent: If its jury or of		20a. Method of Disposition  1	Removal from State Wester	y, crematory or other place)		20c. Location - City or To Baltimore W	1D
Ba	permit. Departr Importe any inji		21. Signature of Funeral Strvice ic	mil	Gay P. murch F		Iton Pass Bal	to., mo 2122
8760, -	The law requires that the death certificate be executed x x x x ten has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	dical Examiner	23a. Parv. Fir. the disease, or compositive shock or near failure. List only of immediate ause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ilications that caused the death. Do not not cause on each line.  a	re Meart notic Neart	Jac Luve Diseas	est,	Approximate Interval Between Onset and Death  Conset and Death  Conset and Death
.O. Box 6	the death certific y the attending p Iched for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25€ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ory Day Year
ds, P	uires that the de n signed by the a ld be detached f	by	Part II. Other significant conditions of	entributing to death but not resulting in	the underlying cause given in Part	t I. 23e. Did to	pacco use contribute to the	ne cause of death?
Vital Records,		Completed	Dementio	(sencle)		24a. Was a autops perfor	y prior to con ned? death?	psy findings available inpletion of cause of 2 No
Š	ysician s certifi director	To Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) Yes	Hospital: 1 ☐ Inpatient 2 ☐ ER/Qu	0.11	ce of Death <i>(Check only or</i> Nursing Home 5 X Reside		41
on o	iding Phy th. : After thi : funeral o		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. 1	ime of hjury at Work?  M 1 Yes 2	28d. Describe he	ow injury occurred	/
Division of	To the Hospital or Attanding Physician: whith 24 hours after deals as a fire deals To the Funarel Director: After this certifies completely filled in by the funeral director; g	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)			reet and Number or Rural n, State)	i Route Number,
	P Hospi 24 hou P Funar etely fill	edical	29a. Certifier (Check only one) Certifying Phy	sician: To the best of my knowledge iner: On the basis of examination and manner stated.	, death occurred at the time, date a d/or investigation, in my opinion, de	and place, and due to the c eath occurred at the time, d	ause(s) and manner as state and place, and due to	ated. the cause(s)
<b>&gt;</b>	To th within To th compl	Me	29b. Signature and atte of certifier	Chine mi	29c. License number $13624$		9d. Date signed (Month, I	Day, Year)
	2	1	30. Name and address of person who co	ompleted cause of death (Item 23a) ( EMD 606 Ham	Type, Print) monds La, St	e L-2 Broo	belyn Park	MD 21515
	Sta Registr	av.	SEP 1 0 2004	Hegistrar's Signature	had.			3

		•	For State Registrar	State of Mar	yland / Depa		lealth a	-	_	04.	20021	2
ı	Physicia /Medic		Decedent's Name (First, Middle, Las Elizabeth Alice Mi					2. Date of D. Month Septemb	4 - 4 -	Year	3. Time of Death 1:25 P	М
,	Examin		4a. Facility Name (If not institution, give Manor Care Rossville			4b. City, Town, o Baltimore	County		Balti			
	Funeral Director		5. Social Security Number  2 (6-50-304)  Usual Residence of Decedent	ex 7. Age (i ☐ M 2☐ F 89	In yrs, last birthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min. 8. Date of Bi (Month, D	r 19 1914	9. Birth Cour Balt	place (State or Foreigntry) impre, Mary La	ign a <b>n</b> d
death with the Maryland	r 28e-f show	Director	10a. State 10b. County  Maryland Baltimore  10e. Street and Number	1	Oc. City, Town or Lo				10g. Citizen of		10d. Inside City Limit 1 ☐ Yes 2 ☐ N X ntry?	
		by Funeral D	42 Powderview Court  11. Maritat Status  1 Never Married 2 Married 3 Never Married 4 Divorced	12. Was Decedent Ev. Armed Forces? 1 ∐Yes. 2 ☑ No If Yes, Give Year or Dates:		21236 Was Decedent of Hit Yes, specify Cub		in? (Specify Yes or N Puerto Rican, etc.)	USA o- 14. Ra BI Spec	ace - Americack, White,	etc.	
21215-0036 within 72 hours after	ijene. r than "natural" Ine Medical Ex	Completed b	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of d)	of working	16b. Kind of	Business/In	ite dustry Own Hame	
Maryiand 2 d 2 should be filed	ad othe	To Be C	17. Father's Name (First, Middle, Last) Anton Zeman				Marie (				Code	
_ č	Health a em 27 ls ther tra		19a. Informant's Name/Relationship ( Thomas A Miskimon  20a. Method of Disposition			oderview Co	urt B	or Rural Route Numb altimore Mar Date	ryland 21 20c. Location	236		
<b>Baltimore,</b> permit. Pages 1 ar	Department of Importent: If it any injury or o		1 ⊠ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specification of Funeral Service Licer	y)	Bohemian I	Vational Ce	metery:	Sept. 10 200 me Inc altimore, Mar	4111		<i>i</i> land	
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760, te be executed III		lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	consequence of):	melin e	ton	x D	11 tran			
O. Box 68 the death certifical	ed by the attending p detached for use as I	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	pregnancy  Fetat death 3	□Ectopic pregnanc □ Other (specify) _	у			ate of deliv	ery Day Year	
Vital Records, P.O. Box 68 sician: The law requires that the death certifica	has been signed by ge 2 should be deta	Completed by Ph	Part II. Other significant conditions of	contributing to death but	not resulting in the t	rnderlying cause gr	ven in Part I.	24a. Wa aut	Yes 2 No	3 Prol	he cause of death? bably 4 ⊟⊎nknow ppsy findings availat impletion of cause o	wn 
ral Ra	ilicate h or, page		25. Was case referred to medical				26 Place	pen 1 ☐ Yes of Death (Check only	formed? 242 No	death?	2□ No	
of Vi	his cert I direct	To Be	examiner? 1 □ Yes 2 □ No	Hospital:		nt 3 DOA	her: 4 Nur	sing Home 5 Res	sidence 6 🗆 O		(y)	
Division of	death. ctor: After t / the tunera	Certification:	27. Manner of Death  1	99 Ptage of Laive	Year) 28b. Time of Injury	M 1	ryat rk? ]Yes 2□N	lo	how injury occi		al Route Number.	
Division of Vita	within 24 hours after death.  To the Funeral Director: After this certilicate ha completely tilled in by the funeral director, page			building, etc.  nysician: To the best of miner: On the basis of e	(Specify) my knowledge, dea	th occurred at the ti		place, and due to the				
Tothe		Medical	29b. Signature and title of certifier	and manner state		29c. Licen	se number		29d. Date sign			
	Sta Regist		30. Name and address of person who SHOA[J] A.  31. Date filed (Month, Day, Year)	HASHM 32. Registrar	) 82 's Stignature			au St	Gente	308	- Balt	112
DHM	H 17 Rev 1/2	2001	SEP 1 0 2	004 Seems	ORIGIN	Al.						

dic	ın	Decedent's Name (First, Middle, Last				of H		2. Date of De Month	Day Y	3. Time of Death
:uic	al	George Rodger Ma						Septem		
min	er>	4a. Facility Name (If not institution, give Collinswood Nurs	street and number) ing Home an	d Rehab	4b. City, 1 Roc	kvi.	Location of Dea LLe	tn	4c. County of Montgot	nery
ral or		377 07 0 132	x 7. Age (I x 2 F 88	n yrs. last birthda Yrs.	Months	1 Year Days	If Under 24 Hrs Hours Min	(Month, Da	iy, Year)	Birthplace (State or Foreig Country) Maryland
S	-	Usual Residence of Decedent  10a, State 10b, County	11	Oc. City, Town or	Location					10d. Inside City Limits
9005	to	Md Montgome	ry	Rockvil:	le					1K∐Yes 2 ☐ No
	Director	10e. Street and Number			10f. Zip	Code			10g. Citizen of Wh	at Country?
İ	<u>a</u>	13504 Oriental St	reet		2	2085	3		U.S.A.	
	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ♣ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1942- 1945	3. Was Decedo If Yes, spec 1 Yes 2		spanic Origin? ( n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
	ed	15. Decedent's Ed		16a. De	cedent's Usua	l Occupa	ation		16b. Kind of Busi	
	Completed	(Specify only highest grad		(Gi	ive kind of wor a. DO NOT us Statio	k done d e retired on E	uring most of wo ngineer	orking	A.T.C.C	•
	BeC	17. Father's Name (First, Middle, Last)							, Maiden Sumame)	
	2	George R. Mays	Sr.				<del>Vera We</del>	nk Nel	lie Palme	r
	9	19a. Informant's Name/Relationship (7) Donald P. Mays/So							er, City or Town, St Md 20853	ate, Zìp Code)
	I	20a. Method of Disposition		20b. Place of Dis	sposition (Namerematory or ot	ne of	el l	Date	20c. Location - Ci	ty or Town, State
	П	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	BaltWa				3-04	Laurel,	MD
	d	21. Signature of Funeral Service Licens	see ,						eral Home	,Inc.
once	1	Xenua Stow	ut moi	338 7	601 Sar	ndy	Spring H	Rd. Laure	e1, Md 20	707
n		23a. Part I Enter the disease, or comp shock, or heart failure. List only of Immediate Cause Final	lications that caused thene cause on each line.  Heart Fa		enter the mode	e of dying	g, such as cardia	ic or respiratory a	rrest,	Approximate Interval Between Onset and Death
ı		disease or condition resulting in death)	Due to (or as a c							
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Congest:	ive Card	iomyopa	athy				Years
	Ical Exan	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):						
	/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. Date	of delivery
- I	by Physiclan/Med	in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim 9 ☐ Unknown		3 □Ectopic pre 5 □ Other (spe				Month	n Day Year
	2		notributing to death but a	ot resulting in the	e underlying ca	ause give	on in Part I.		obacco use contrib	ute to the cause of death?
		Part II. Other significant conditions or						1 🗆		Probably 44 Unknow
		Part II. Other significant conditions of	minibuling to usual section					24a. Was auto perfe	psy prio prmed? dea	
	Completed	25. Was case referred to medical	This builty to could built built				26. Place of De	24a. Was auto perfe	psy prio prmed? dea 2 2 3 No 1	are autopsy findings available for to completion of cause of ath?
	Be Completed	25. Was case referred to medical	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpat	tient 3□ DO	-	ar: 4⊠ Nursing	24a. Was auto perfo 1 Yes	psy prio prmed? dea 2 2 3 No 1	ore autopsy findings available or to completion of cause of ath? I Yes 2□ No
	To Be Completed	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 11 Natural 5 Pending investigation	Ho spital: 1 □ Inpatient 28a. Date of Injury (Month, Day Y	(ea <i>r</i> ) 28b. Time	tient 3 DO	8c. Injury Work	ar: 4⊠ Nursing	24a. Was auto perfect of the control	psy price pr	are autopsy findings available or to completion of cause of all ? ] Yes 2 \[ \text{No} \] (Specify)
	ertification: To Be Completed	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	Hospital: 1 □ Inpatient 28a. Date of Injury (Month, Day Y	(ear) 28b. Time Injur	tient 3 DO	8c. Injury Work	ar: 4⊠ Nursing rat k?	24a. Was auto perfect of the control	psy price of the p	ore autopsy findings available or to completion of cause of ath?  Yes 2 \[ \] No
	Certification; To Be Completed	25. Was case referred to medical examiner?  1	Hospital: 1  Inpatient  28a. Date of Injury (Month, Day Y	ear)  28b. Time Injur  At home, farm, Specify)  ny knowledge, de (amination and/or	tient 3 DO a of 28 y M street, factory,	8c. Injury Work 1 1 '	ac 4⊠ Nursing rat '? Yes 2 □ No	24a. Was auto perfect of the perfect	psy price pr	ore autopsy findings available or to completion of cause of ath?  Yes 2 No  (Specify)  or Rural Route Number,
	ertification: To Be Completed	25. Was case referred to medical examiner?  1	Ho spital: 1 Inpatient 28a. Date of Injury (Month, Day Y) 28e. Place of Injury building, etc. ( ysicien: To the best of riner: On the basis of ex-	ear)  28b. Time Injur  At home, farm, Specify)  ny knowledge, de (amination and/or	street, factory,  sath occurred a rinvestigation,  29c.	8c. Injury Work  1 1 7	ac: 4⊠ Nursing rat rat rat res 2 □ No res, date and plac pinion, death occ e number	24a. Was auto perfect of the perfect	psy price pr	ore autopsy findings available or to completion of cause of ath?  I Yes 2 No  (Specify)  or Rural Route Number, her as stated. d due to the cause(s)
	edical Certification; To Be Completed	25. Was case referred to medical examiner?  1	Ho spital: 1 Inpatient 28a. Date of Injury (Month, Day Y) 28e. Place of Injury building, etc. ( ysicien: To the best of riner: On the basis of ex-	ear)  28b. Time Injur  At home, farm, Specify)  ny knowledge, de (amination and/or	street, factory,  sath occurred a rinvestigation,  29c.	8c. Injury Work 1 1 1	ac: 4⊠ Nursing rat rat rat res 2 □ No res, date and plac pinion, death occ e number	24a. Was auto perfect of the perfect	psy price pr	ore autopsy findings available or to completion of cause of ath?  I Yes 2 No  (Specify)  or Rural Route Number,  where as stated, did due to the cause(s)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 25, **Physician** Roosevelt Mallory 2004 August 12:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8 Payne Lane E1kton Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. Mar 28, 1928 5. Social Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1፟፟፟∭M 2□F 76 Tennessee Director 498-26-4746 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show the Medical Examiner nust by notified at 1 ☐ Yes 2√ No Funeral Director Cecil Elkton the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 8 Payne Lane USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural, or Item any injury or other traumatic event, the Medical Examples. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: black þ 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4or 5+) Dept of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rooselvelt Mallory Sr Winnie Grant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9747 S. Drexel Avenue Chicago, IL 60628 Minnie Rooks/cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State `4 □Donation 5 NOther (Specify) in state 21. Signature of Hyneral Service Licensee Wade State Anatomy Board 655 W. Baltimore Street wowl Baltimore, MD 21201 23a. Part. Enter the disease, or/complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cluse (Final disease or condition resulting in death) **Physician** ung year 60 mall /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicism: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2PTNo 1 Yes 2 No 1 Tyes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending To the Hospins after death.

To the Funeral Director: Aft investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 00035779 August 31, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bohemia Ave, Lecilton, M. 2.1913 Wi Bruce Obens 25/5, hain 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 1 0 2004 Sparks

December   March   M				1 - For State Registrar	State of Mary		artment tificate				Reg. No.	004	2882	26
## A Facility Name of the Instance of pass owner and number?    Prince   Pr										Month	Day			
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Common Section   Power   Common Section   Common Sectio				University of Maryle	and Medic	al Center	Ba					NΑ		
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All and the second program of the second pro	n n	d is d	Be						8. Mother's Na	ame (First, Middle				
Amanda Nelson Mother 520 N. Robinson Ave., Baltimore, Md. 21205    Amanda Nelson   Date   Dat		2 ≥ 2 2	2				a Address	(Street and					0-4-1	
Sequentially list conditions   Claremouter from Siate   Voshe11 Mem. Garden   9-11-04   Dundalk, Md.		C C - 6			•									
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Approximate   Compare	Ĕ	Page ment ant: If			emoval from State	-			en   9-1	11-04	Dunc	dalk, Mc	l.	
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FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   yes 2   No 9   Unknown   9   Un		sate be executed physician and the burial-transit	Examin	Cause (Disease or injury that initiated events	)									
25. Was case referred to medical examiner?    The state of the state o	DOX	the death certific y the attending p tched for use as		23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3					230		-	əar
25. Was case referred to medical examiner?    The state of the state o	ras, r	quires that in signed b uld be dett	by	Part II. Other significant conditions con	stributing to death but no	ot resulting in the ur	iderlying cai	use given i	in Part I.		_			
27. Manner of Death   1	r	The ate ha	O							autop perfo	osy ormed?	prior to cor death?	npletion of car	
1 Natural 2 Accident 3 Suicide 4 Homicide 4 Homicide 5 Pending investigation 6 Homicide 4 Homicide 4 Homicide 9 Suicide 4 Homicide 9 Suicide 4 Homicide 9 Suicide 4 Homicide 9 Suicide 4 Homicide 9 Suicide 4 Homicide 9 Suicide 4 Homicide 9 Suicide		/sicial	00	examiner?	ospital:	2 □ EB/Outpatient	3□004					Other (Coasile		-
29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month Pay Year)		nding Phy ith. : After this e funeral c	$\vdash$	27. Manner of Death 1 ★ Natural 5 □ Pending	28a. Date of Injury	28b. Time of	28	c. Injury at Work?					9	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	DIVIS	tal or Atte s after des al Directo ed in by th		dotominod	28e. Place of Injury - building, etc. (S	At home, farm, stre	eet, factory,	office		28f. Location (5 City or Tox	Street and f vn. State)	Number or Rura	Route Numb	Θ <i>Γ</i> ,
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)		he Hospli in 24 hour he Funera pletely fille	edicai	(Check only 2 Medical Examil	10r: On the basis of exa	y knowledge, death amination and/or inv	occurred at estigation, i	t the time, n my opini	date and place ion, death occ	e, and due to the curred at the time,	cause(s) ar date and pl	nd manner as st ace, and due to	ated. the cause(s)	
State  That I was and address of person who completed cause of death (Item 23a) (Type, Print)  Daphne Friedman 16 South Eufaw Street Baltimore Maryland 21201  State 31. Date filed (Month, Day, Year)  32. Pristrar's Signature		To t To t	Σ	29b. Signature and title of certifier	,		29c.	License ni	umber		29d. Date s	signed (Month, I	Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Daphne Friedman 16 South Eutaw Street Baltimore Maryland 21201  State 31. Date filed (Month, Day, Year)  32. Prints Signature		7		taplue In	deman	MP	F	164	88		0	1/05/0	4	
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		Sta Registr		31. Date filed (Month, Day, Year)	32. Pigistrar's	Signature	and a		DULLING	VIC /VIC	A. Ala	100 21	LU	

			1- For State Registrar		artment of Health and Nartificate of Death		ene 	28827
8	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medio		Catherine L. Oppenheir  4a. Facility Name (If not institution, give street and		4b. Cily, Town, or Location of Death	09	04 2004 4c. County of Death	3:00 AMM
1	Lamii	iei	4260 Chapel Road	,	Perry Hall		Baltimore	<u> </u>
	Funeral		5. Social Security Number 6. Sex 1 ☐ M 2 🔯	7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Y		lace (State or Foreign try)
	Director		213-38-6951 Usual Residence of Decedent	85 Yrs.		12/25/19		yland
	yland yland		10a. State 10b. County	10c. City, Town or L	ocation		1	Od. Inside City Limits
	e Maria-	ctor	MD Baltimore	Perry Ha	all			1 ☐ Yes 2X No
	vith th	Director	10e. Street and Number	•	10f. Zip Code	10g	. Citizen of What Coun	try?
	eath v	eral	4260 Chapel Road	Decedent Ever in U.S. 13	21128		U.S.A. 14. Race - Americ	on Indian
(0	r Itan	Funeral	1 Never Married 2 Married 1 Y	as 2 🗙 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
03	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show dical Exeminer must be neithed at	þ	3 XWidowed 4 □ Divorced If Yes Year of	Give or Dates:	1 ☐ Yes 2 🕅 No Specify:		Specify: Whi	te
21215-0036	"natu	Completed	15. Decedent's Education (Specify only highest grade complete	ed) (Giv	edent's Usual Occupation a kind of work done during most of work	ing 16	b. Kind of Business/Inc	lustry
112	d within giene. r than "	дшо	Elementary/Secondary (0-12) Collect	le (1-4or 5+)	DO NOT use retired)  counts Payable Clei	ale ·	Exxon Corp.	
	Hyge II	Be C	17. Father's Name (First, Middle, Last)	ACC		e (First, Middle, Ma		•
ylar		ToE	William Dietz		Caroline	e Roeder		
Maryland	and and Is m		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Number or Rura	al Route Number, C	City or Town, State, Zip	Code)
	1 and Healt am 2 thar		Marie McKelvey (daugh	50 Chapel Road - Pe		<ul> <li>Maryland</li> <li>c. Location - City or To</li> </ul>	21128	
nor	S = = 0		1 XBurial 2 ☐ Cremation 3 ☐ Removal fr '4 ☐ Donation 5 ☐ Other (Specify)	om State cemetery, cre	nmatory or other place)		,	2012
altimore,	그 돈 돈 글		21. Signature of Funeral Service Licensee	St. Step	nen ChurchCem. $09/0$	F. Lassa	Bradsnaw, B hn funeral	Maryland Home, P.A.
ñ	Depa Depa Impo any ir		J. C. S. Lasses		1750 Belair Road -			
	Pnysician /Medical Examiner	ı		to (or as a consequence of):	tory failure	or respiratory arrest	~	Approximate Interval Between Onset and Death S Months
( 68760, I	rtificate be executed ing physician and as the burial-transit	Medical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence of): to (or as a consequence of):		1		
О. Вох	that the death certificate ed by the attending phys detached for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	ry Day Year
of Vital Records, P.	Se US	by	Part II. Other significant conditions contributing to	o death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?
000	> 0 2	pleted	$\mathcal{O}^{*}$			24a. Was an	24b. Were autop	isy findings available
R	The te h age	ompl				autopsy performed 1 ☐ Yes 2 ☑	d? death?	pletion of cause of
25. Was case referred to medical examiner?  Hospital:  Other								
of \	ys di S	၉	1 ☐ Yes 2 No Hospital: 1		e 6 Other (Specify	)		
no	ding h. After fune	tlon	1 Natural 5 ☐ Pending (A	ate of Injury fonth, Day Year) 28b. Time of Injury	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division	or Attending after death. Diractor: After in by the fune	ertification;	3 Suicide 6 Could not be determined 28e. Pl	ace of Injury - At home, farm, si			at and Number or Rural	Route Number,
á	p ag in in	Cert	4 Homicide determined bu	ilding, etc. (Specify)		City or Town, S	State)	
	To the Hospital or All within 24 hours after or To tha Funaral Dirac completely filled in by	edical (	(Check only 2 Medical Examiner: On the	the best of my knowledge, dea e basis of examination and/or in anner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the caus ed at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)
	To t To tl	ž	29b. Signature and title of certifier		29c. License number		Date signed (Month, E	
,	n	10	I said Many	no	D16587	<	September 7	1, 1004
	19	ii)	30. Name and address of person who complete to	/ ^		2120	W	
	Sta	te	31. Date filed (Month, Day, Year) 3:	60 OS C Br	1. 20	0100	/	
	Registr	ar	SEP 1 0 2004	Aller D.	and a second			

OLIVER, LOUISE M

			Please T	Type or Prin				_		gible.	
			1_ For State	State of Ma		partment of I		Mental H	ygiene	01 00000	
	_		Registrar  1. Decedent's Name (First, Middle, Last)			ertificate of	Death	2. Date of D	Reg. No.	U4 60060	
	Physic		Louise W. Olive					Month	Day 4	Year 2010P	м
1	/Medi Examir		4a. Facility Name (If not institution, give			4b. City. Town.	or Location of Dea	SEPTEN		, 2004 20101 nty of Death	_
	LAGITIII	ICI	SAINT AGNES		HCARE		IMORE	-		, 5. 250	
	Funeral	П	5. Social Security Number 6. Sec	7. Age	(In yrs. last birthda				irth Jay, Year)	Birthplace (State or Foreign Country)	gn
ч	Director		214-18-1340	]M 2⊠F	89 Yrs	World Days	riodis Will	Jan. 3	0,1915	Pennsylvania	_
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limit	ts
	Manyl f sho	ō	Maryland Balti	imore	Cat	onsville				1 □ Yes 2√€ N	
	r 28a	Director	10e. Street and Number	Linote	- Oat	10f. Zip Code			10g. Citizen	of What Country?	
	be filed within 72 hours after death with the Maryland tal Hygiene. ad other then "natural", or Items 23a or 28a-f show event, the Madical Evarring must be notified at	a D	912 South Rolling	Road		212	228			U.S.A.	
	ems	Funeral		12. Was Decedent E Armed Forces?	ver in U.S. 1	3. Was Decedent of I		Specify Yes or N	lo- 14. F	Race - American Indian, Black, White, etc.	
36	or it		1 Never Married 2 Married	1 ☐ Yes 2 🔯 N If Yes, Give	0	1 ☐ Yes 2 ♣ No		10 1 110411, 010.)	Spe	cify:	
8	hour:	Completed by	3 A Widowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:	160 D-	cedent's Usual Occu				White	
15	in 72 n "na n adic	plet	(Specify only highest grade	e completed)	(G.	ve kind of work done  DO NDT use retire	during most of wo d)	orking	160. Kind of	Business/Industry	
212	filed withi Hygiene. Ither ther	mo.	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Homemaker			Ow	n Home	
þ	be filed tal Hyg d othe event,	Be C	17. Father's Name (First, Middle, Last)					me (First, Middl			_
<u>la</u>	should be filed within and Mental Hygiene. s marked other then umatic event, ITE M	10	William Washingtor	n Wysor			Mamie T	rent Fa	gg		
a	0 00 00	10 3	19a. Informant's Name/Relationship (Ty			iling Address (Street			-		
2	as 1 and 2 should of Health and Mer item 27 Is marker other treumatic		William H. Oliver	(Son)		naxton Cou	rt Timon				
Baltimore, Maryland 21215-0036	0 0		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R	lemoval from State	cemetery, c	position (Name of rematory or other pla	. 1	Date	20c. Locatio	n - City or Town, State	
Ē			' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of uneral Service License			n Cemetery		1-2004	Woodla	wn, Maryland	_
Ba	permit. Departri Importe any inju	١.,	21. Signature of uneral Service Licensis	2/	Mes	Vitzke Fur	eral Hom	e of Ca	tonsvil	le, Inc e, MD 21228	
			23a. Part1. Enter the disease, or sompli	ications that caused	the death. Do not					Approximate	
	Pnysician		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each lin	e. T1C					Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of):						_
	Examiner		Sequentially list conditions,	SEVE	REI	EMEN	ITIA.				
10	D #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):						
A .	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	). Due to for each							
60,	be ex ician burial			Due to (or as a	consequence of):						
687	leath certificate b attending physic I for use as the b	Physician/Medical		Table 1				88			-
Box (	certif nding use a	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of	of pregnancy				234 [	Date of delivery	
ğ	death e atte	Cla	in the past 12 menths?	1□Live birth 2 4□Pregnant at		3 □Ectopic pregnanc 5 □ Other <i>(specify)</i> _	у			Month Day Year	
O.	at the d by the tached	hys	9 Unknown	9□ Unknown							
S, D	The law requires that the death certificate te has been signed by the attending physoage 2 should be detached for use as the	by P	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco use co	ontribute to the cause of death?	
ord	w require been sign							1 🗆	Yes 2 ☐ No	3 Probably 4 Unknow	n
ecc	lawr as be 2 sh	Completed						24a. Was		Were autopsy findings available prior to completion of cause of	
- H		Con						perf 1 ☐ Yes	ormed2 2 No	death? 1 ☐ Yes 2 ☐ No	
Vital Records,	Physicien: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	la a situli				ath Check onl	one		
of	Phys this al dii	5 1	1 Yes 2 No  27. Manner of Death	lospital: 1 Inpatier		BIIL 3 DOA		lome 5 Res			
no		lon	1 Natural 5 ☐ Pending	28a. Date of Injun (Month, Day	Year) 28b. Time Injur	/ Wo		28d. Describe	how injury occ	urred	
Division	ten leat tor: the	fica	3 Suicide 6 Could not be	28e. Place of Inju	rv - At home, farm.	street, factory, office	163 2 110	28f. Location	(Street and Nur	mber or Rural Route Number.	=
Ω	in Light	Certification;	4 Homicide determined	building, etc.	(Specify)				wn, State)		
	Hospitel 4 hours a Funerel iely filled		29a. Certifier 1 Certifying Phys	sician: To the best o	f my knowledge, de	ath occurred at the ti	me, date and place	a, and due to the	cause(s) and r	manner as stated.	-
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	(Check only 2 Medical Examir one)	ner: On the basis of and manner stat	examination and/or	investigation, in my o	pinion, death occu	urred at the time	, date and place	e, and due to the cause(s)	
	To the company	Σ	29b. Signature and title of certifier			29c. Licens	se number	2	29d. Date sign	ned (Month, Day, Year)	-
			1 (Kama	NI		Pl	862	5	Septe	mber 7,2000	f
	1		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Typ	e, Print)		- 00-		1 = PA :	
			CHAUHAN, CHAN 31. Date filed (Month, Day, Year)	DANA, M	I.D. ST. A	SNES HEA	LTHCARE	100 C	ATON F	mber 7,2000 AVE, BALTIMORE	M
	Sta Registi		SEP 10	32. Regist	due &	Societies					

			1 - For State Registrar	State of Ma	arylar	id / Depa		Health a	and Mer	ital Hygi	ene g. No. () () ()	28829
	Physici /Medio		Decedent's Name (First, Middle, Last	Margar	et	Per	seghin			Date of Death Month Ppt.	3 2004 Year	3. Time of Death 4:00p M
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town	or Location			4c. County of Dea	ith
			Bayview Hospi					timore			n/a	
	Funeral Director		211 03 2023	7. Age	e (In yrs. 8	ast birthday)  3 Yrs.	If Under 1 Year Months Day		Min.	Date of Birth Month, Day, arch1	9. Bit 4,1921 M	thplace (State or Foreign ountry) aryland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	y, Town or Lo	cation					10d. Inside City Limits
	within 72 hours after death with the Maryland ene. than "naturel", or liems 23a or 28e-f show the Madical Examiner must be notified at	ector	MD Baltimo	re				imore		46		1 ☐ Yes 2 No
	with with	Dir	616 South New	kirk Str	eet		10f. Zip Code 212				lg. Citizen of What C SA	ountry?
	death	era	11. Marital Status	12. Was Decedent B		.S. 13. V	Vas Decedent o		igin? (Specify		14. Race - Am	erican Indian,
36	rs after f, or ite	by Funeral Director	1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2♥ N If Yes, Give Year or Dates:	ю		Yes, specify Cu			n, etc.)	Black, Whi	
ਖ਼	2 hou ature	ted	15. Decedent's Edu	ucation		16a. Deced	ent's Usual Occ	upation		1	6b. Kind of Business	/Industry
212	hio 7.	ple	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5	+)	(Give :	kind of work dor OO NOT use reti	e during mos red)	t of working		CrownCor	
21	ed wil	Completed	8th			Asse	embly 1	T-				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department if time 27 is marked other than "naturel; or items 23a or 28e-f show any injury or other treumatic svent, the Macilcal Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last)  Edward Dunni	gan / s	on			_	er's Name <i>(Fir</i> ie Kar		aiden Sumame)	
	s 1 and 2 sho of Health and I item 27 is ma other treuma		19a. Informant's Name/Relationship (T) Bruno Perseghi								City or Town, State, ID 2122	Zip Code)
ē,	s 1 a of He item othe		20a. Method of Disposition		20b. F		sition (Name of latory or other p		Date		Oc. Location - City or	Town, State
Ĕ.	Pages nent of i ant: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)				Cemete		9/9/0	) 4 I	Baltimor	e MD
Baltimore,	permit. Departr Importe any inje		21. Signature of Funeral Service Licens	99	0	22	Name and Add		COIII		TuneralHo	omeofEssex
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ications that caused ne cause on each lir	the deat	n for hot ente						Approximate Interval Between Onset and Death
F	nysician /Medical		disease or condition resulting in death)		tro							
	Examiner			Due to (or as a		uence on: rtensi	On					20years
Ţ		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a			.011					Zoyears
9/60,	ate be executed hysician and the burial-transit	ilcal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a	a conseq	uence of):						
O. Box 6	the death certifically the attending phy the attending phyched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Feta	Ideath 3□	Ectopic pregnan Other (specify)	cy			23d. Date of de Month	ivery Day Year
Records, P	luires that the de n signed by the a ild be detached f	by	Part II. Other significant conditions con Anemia			ulting in the un		iven in Part I.			cco use contribute to	o the cause of death?
ဝ္ပ	s been si	Completed	Renal failure							24a. Was an	24b. Were au	Itopsy findings available
֓֞֟֞֝֟֞֓֓֓֓֟֟֝֓֓֓֓֟֟	te ha	шо	Heart failure				<del></del>			autopsy perform 1 🗀 Yes 2	prior to death?	completion of cause of 2 ☐ No
<u>.</u>	urtifica ctor, p	Bec	25. Was case referred to medical					26. Place	of Death Ch			2   NO
>	Pnysicien: The lav r this certificate has ral director, page 2	To	examiner? 1 ☐ Yes 2XX No	Hospital: 1 ☐ Inpatie	nt 2	ER/Outpatient	3□ DOA O	ther: 4 🗆 Nu	rsing Home	5 🗌 Residen	ce 6 ⊡Other (Spe	cify)
פוסו	After uner		27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	28c. Inj W	uryat ork? ∐Yes 2 ∐≀	28d.	Describe hov	injury occurred	
=	or A fter Direction by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At ho . (Specify	ome, farm, stre	et, factory, office	)	28f. L	ocation (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	lothe Hospitel or within 24 hours afte To the Funeral Dire completely filled in t	Medical C	29a. Certifier (Check only one) 1 🔀 Certifying Phy 2 🗋 Medical Exemi	sician: To the best of ner: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurred at the estigation, in my	time, date and opinion, deal	d place, and d th occurred at	lue to the cau the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
	within To th	Me	29b. Signature and title of certifier		-		29c. Licer	se number		29	d. Date signed (Mont	h, Day, Year)
,			1 Iromas	truc	بند	~		24	(334	4	9 191	04
	^		30. Name and address of person who co	ompleted cause of de	ath (Item	23a) (Type, F	rint)			1	+ 1 + 1	
	10		Dr.Finucane	JHBMC								
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 0 2	32. Registra	r's Signa	ture &	Soon	161				

			For State Registrar	State of Marylan		rtment of F		-	giene	28830
	Physicia		1. Decedent's Name (First, Middle, L	Last)				2. Date of De Month	nath Day Yea	3. Time of Death
	/Medic Examin	al .	Eunice Irene 4a. Facility Name (If not institution, g			4b. City, Town, o	r Location of Death	Septem	ber 3, 200 4c. County of D	
			Gilchrist Nurși			Towson	1411-40411-		Baltim	
	Funeral Director		5. Social Security Number 6. 242-05-1586	S. Sex 7. Age (In yrs.	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)
			Usual Residence of Decedent	A 84				Octobe	r 4,1919 N	Morth Carolina
	rylanc how		10a. State 10b. County	10c. Cit	ty, Town or Loc	ation				10d. Inside City Limits
	72 hours after death with the Maryland naturel', or Items 23s or 28s-f show alcal Evertil or mast be marified al	Director	MD Balti	more D	undalk					1 ☐ Yes 2 🔼 No
	vith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
P	eath v		1701 Kirkland	Rd .	19 13 W	21222	lienanic Origin? (Sp.	acity Yes or No	USA	mencan Indian,
M	fter d	Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?			lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, W	
	al', o	by	3 ₩ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2∑X No	Specify:		Specify: W	hite
	be filed within 72 hours after death with the Marylan lat Hygiene. And other than "natural", or liems 23a or 28a-f show event, the Medical Evernity in the first filed at	Completed	15. Decedent's (Specify only highest of		(Give k	ent's Usual Occup	during most of work	ing	16b. Kind of Busine	ss/Industry
0 5	within ene. than "	mpi	Elementary/Secondary (0-12)	Coilege (1-4or 5+)		O NOT use retired	d) -			
	should be filed within to Mental Hygiene. marked other then imatic event, the Marked		12 17. Father's Name (First, Middle, La	ast)	Assemb	ter	18. Mother's Name	(First, Middle	Manufactu . Maiden Sumame)	ring
<u>ੂੰ</u>	d be ental kad o	To Be	W4114 # D				Fallie	Tomas	,	
೧೯೭, ೦ <sub>3 ,</sub> Marvland	should ind Men marka umatic	-	William H. Proc 19a. Informant's Name/Relationship	p (Type, Print)	19b. Mailing	Address (Street		Jones al Route Numb	er, City or Town, State	e, Zip Code)
· Comme	and 2 alth a 27 is ar tra		Susan F. Fischba	(Daughter in law)	2110 C	ak Rd.	Baltimore	MD.	21219	
1, Scottmisse,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is market any injury or other traumatic. once	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		Place of Dispos cemetery, crem	ition (Name of atory or other plac	(ec	Date	20c. Location - City	or Town, State
S. S.	Pag ment ant: J		Donation 5 Other (Spe	city) Flo					High Poin	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Depart Depart Import any in		21. Signature of Funeral Service Lie	269AS00	Model				Funeral H	ome of
Friens,	40240	5011	23a. Part1. Filter the disease, or co	omplications that caused the deal						Dundalk, Inc. Approximate
<u></u>			or heart failure. List on	nly one cause on each line.	DO 1101 O1110	172 m	-	n respiratory a	11031,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to (or as a conseq	Juanca of):	Cana	علا			MINING
	Examiner				querice orj.					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b.  Due to (or as a conseq	quence of):					
	cuted	Examiner	that initiated events	С						
19092	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conseq	quence of):					
- 00		dicai		d						
9	death certifice e attending ph d for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	ancy		·		23d. Date of	delivery
43 Box	Jeath atter	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		ctopic pregnancy Other (specify)	/		Month	Day Year
P 0	that the c ed by the detached	hysi	9 Unknown	9□ Unknown						
J 0	es that the death certific igned by the attending be be detached for use as	by P	Part II. Other significant conditions	s contributing to death but not res	sulting in the un	derlying cause giv	en in Part I.	23e. Did t		to the cause of death?
200	w require been sig	ted						10	Yes 2 No 3□	Probably 4 ☐Unknown
- 03-04 Record	The law requires ite has been sign bage 2 should be	Completed						24a. Was	psy prior t	autopsy findings available to completion of cause of
		Соп				_		perfo 1 🗆 Yes	ormed? death	? es 2 No
Vital Vital	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		3CI DOA Oth	26. Place of Death		2002	
3 5	Phys	: To	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 2	ER/Outpatient 28b. Time of	3 LI DOM	4   Nursing no		dence 6 (ther (S)	pecify) Hospice
Cunica ion of	Attending I r death. sctor: After by the funer	ition	1 Seatural 5 ☐ Pending 2 ☐ Accident investigat		Injury	28c. Injur Wor M 1 🔲	k? Yes 2 □ No			
<u>v</u>	l or Attencafer death Director: in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine		ome, farm, stre	et, factory, office		28f. Location ( City or To	Street and Number or	Rural Route Number,
S	tal or A	Cert	4 1 Iomicide	building, etc. (Specia	(y)			City of 701	wii, State)	
ARRESH	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier Certifying	Physicien: To the best of my know xeminer: On the basis of examina	owledge, death	occurred at the tir	me, date and place,	and due to the	cause(s) and manner	as stated.
Q	tha thin 24 tha f	Medical	one)	and manner stated.		29c. Licens			29d. Date signed (Mo	
	To voit		29b. Signature and title of certifier	l		7	8303		September	
	/		30. Name and address of person wh	to completed cause of death fits	m 23a) /Timo 5				6601 N. CI	
	6		So, Name and address of person with	no completed cause or death (Iter	20a) (19pe, P	1014)			Towson. Mc	
1	Sta	te	31. Date filed (Month, Day, Year)	3 Registrar's Signa	ature				LOWDOIL III	<u>2120</u> 4
	Registr	ar	SEP 1 0 21	004 Mores de	7 ana	des				

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of W	arylanu / i	Certificate of L		, ,	. No.2 () () L	28831
			1. Decedent's Name (First, Middle, Last)	1			2. Date of Deeth Month	Day Yea	3. Time of Death
	Physici /Medio		HENRY 12	104	•			er 3 2004	
1	Examir		4a Facility Name (If not institution, give street and number,		4	b. City, Town, or Loc	ation of Death	4c. County of De	
			GENESIS ELDER CARE-RAND			RANDALLS  If Under 24 Hrs.		BALTI	
	Funeral Director		5. Social Security Number  2.1.5−2.8−6.3.0.6  Usual Residence of Decedent  6. Sex  1.33 M 2□ F  7. Ag  7. Ag	ge (In yrs. last bi	Yrs. Months Days	Hours Min.	B. Date of Birth (Month, Day, ) June 9 ]		Birthplace (State or Foreign Country) IARYLAND
	/lend		10a. State 10b. County	10c. City, Tov	wn or Location				10d. Inside City Limits
	Man a-feh	ţo	MARYLAND BALTIMORE CO	R/	ANDALLSTOWN				1 ☐ Yes 2 🛣 No
	⊕ or 28	Funeral Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What	Country?
	ath w	ral	9109 LIBERTY RD		21133			U.S.A.	
	er de	E	11. Marital Status 12. Was Decedent Armed Forces	?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spec n, Mexican, Puerto R	ofy Yes or No- lican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
Maryland 21215-0020	s 1 end 2 should be filed within 72 hours effer death with the Marylend if Health end Mental Hygiene. Itam 27 ie merked other than "natural", or flems 23s or 28s-f ehow other traumatic event, the Medical Examiner must be recilied at	Completed by F	1 Never Married 2 Married 1 Yes 2 Never Married 2 Married 1 Yes 2 Never Married 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 2 Never Married 1 Yes 3 Never		1 □ Yes 2 XXXIo				BLACK
5	n 72 h	ete	15. Decedent's Education (Specify only highest grade completed)	16a	<ol> <li>Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired</li> </ol>	ation fu <i>ring m</i> ost of working	g 16	Sb. Kind of Busine	ss/Industry
12	withigh within than the Man	d m	Elementary/Secondary (0-12) College (1-4or unknown	5+)	HOUSEKEEPING			DOMESTIC	7
D	Hygi Hygi ent, t	Be Co	17. Father's Name (First, Middle, Last)		11005211221211	18. Mother's Name	(First, Middle, Ma		
<u> a</u>	hental fental ked o	ToB	BOB HEWLETT			EMMA RI	СН		
ary	2 should be filed with end Mental Hygiene ie marked other than surmatic event, the 1		19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing Address (Street a	and Number or Rurei	Route Number, (	City or Town, State	e, Zip Code)
	1 end 2 Health am 27 i		Denise M. Bailey-Jones/Ni		37 Mountain (	Green Circ			
Baltimore,	Peges 1 nent of H int: if itar		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □ Removal from State		of Disposition ( <i>Name of</i> ery, crematory or other plac	е)	Date 20	c. Location - City	or Town, State
Ë	tment tant:		4 ☐ Donation 5 ☐ Other (Specify)		ION CEMETERY		-13-04 I	LANDSDOW	NE, MARYLAND
Bal	permit. Peges 1 end Depertment of Health Important: if item 27 any injury or other to pnce.		21. Signature of Eureral Parvice Handes		22. Name and Addres	BROWN COMM	UNITY FU	JNERAL HO	OME P.A.
	-	T	23a. Par 1. En the disease, or complications that cause	d the death. Do	1206 W NORS		respiratory arres	t,	Approximate Interval Between
1	Physician		shock, or heart failure. List only one cause on each I		-2-1111	000-	7 1 1 5 4		Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	AKZ1	DIOMY	OPA	(17)		
	Examiner	e.	resulting in death)	Due to (or as a	consequence of):			•	
	uted id ensit	Examiner	Sequentially list conditions	Due to (or as a	consequence of):				
ó,	tificete be executed ig physician end es the buriel-trensit	Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,				
68760,	sete b	edicai	resulting in death) Last	Due to (or as a	consequence of):				
		95	d						
Box	eath cert ettendin for use	Physician/N							1
0	thet the dened by the ended to	Jysi	Part II. Other aignificant conditions contributing to death b	ut not resulting i	in the underlying cause give	en in Part I.			Probably Unknown
0	es thet igned b be dete	by PI	CHYZONIC VIE	3-10	MUSUFF	1000	7	2 HO 3	Probably 422 Officiowi
Records,	The law requires thet the death cer ete hes been signed by the ettendir page 2 should be deteched for use	8					24a. Was an		b. Were autopsy findings available prior to
ည္တ	aw re	Completed					perionne	, d :	completion of cause of death?
Ě	The law ste hes page 2	E O					1LLYse	2 Piles	1 ☐ Yes 2 ☐ No
Vital	stan: ertifica	Be	25. Was case referred to medical examiner?	1111	l au	26. Place of Death	(Check only one)		
of	Physician: this certific ral director,	ို	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati	T T		4 Nursing Hom		ce 6 □Other (S	pecify)
L	Ing P	lon	27. Manner of Death  ↑□ Natural 5 □ Pending (Month, Death of Inj.)	y Year)	Time of Injury 28c. Injury Work	Yes 2 □ No	8d. Describe how	injury occurred	
Division	Attanding or death.  • ctor: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of In	iury - At home, f	arm, street, factory, office		Bf. Location (Stre	et and Number or	Rural Route Number,
S	offer Direction of the point of	Certification:	4 ☐ Homicide building, e	c. (Specify)			City or Town,	Stete)	
	To the Hospital or Attanding Physician: The is within 24 hours efter death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one)  Certifying Phyalcian: To the best of the best	f examination er					
	To the I	Me	29b. Signature and title of certifier	1	29c. License	number	290	J. Date signed (Mo	inth, Day, Yeer)
•			Ma	1	NO.	15 6-5K	0	918	104.
			30. Name and address of person who completed cause of	Jeath (Item 23a)	(Type, Print)	USIZ S	いつらば	KESUL	i= ND 2/209
	⊤ Sta	e	1830 01100	rar's Signature	اللا عال	orce s		16 - 20 1C	100000
4	Registr		CED 1 0 2004 Wave	, H.	Sporte				
			JEH - LUUT - CT		/				

DHMH 16 Rev 6/95

			1 - For State Registrar	State	of Maryl	and / Depa <i>Ce</i>	artment o			-	giene Reg. No. () (	Contraction of the Contraction o	28832
			Decedent's Name (First, Middle, L.)	ast)						2. Date of Dea	ath	/ 9	3. Time of Death
	Physici /Medic		DAVID J. RAT	HER						Month SEPTEMB	ER 8, 2	Yeer 2004	2:30 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, ga		ımber)		4b. City, Tow	n, or Locati	tion of Death	DDI IDIN	4c. County		2.30 A
ı			2237 PENROSE AVE	NUE			BALT	IMORE					
	Funeral		Social Security Number 6.	Sex	7. Age (In	yrs. last birthday)		ear If Un	nder 24 Hrs. urs Min.	8. Date of Birt (Month, Da	h Year)	9. Birthp	lace (State or Foreign
	Director		226-14-4848	1XM 2□F	82	Yrs.	WIGHTIG DE	193 1100		MAY 22,		Cour	VA VA
	pur *		Usual Residence of Decedent  10a. State 10b. County		100	. City, Town or Lo	neation					Τ,	0d. Inside City Limits
	/anyli	ō	, , , , , , , , , , , , , , , , , , , ,									'	1 X Yes 2 □ No
	28a-	Director	MD 10e, Street and Number			BALTIMO	10f. Zip Cod	10			10g. Citizen of	Albet Cour	
	hours after death with the Maryland tural', or Itams 23a or 28a-f show al Examiner must be maillised at			MILE				1223			US		uyr
	leath	Funeral	2237 PENROSE AVE	12. Was Dec	edent Ever i	n U.S. 13.			: Origin? (Sp	acify Yes or No-		e - Americ	an Indian
0	r Itan	Fun	1 ☐ Never Married 2 ☑ Married	Armed F	orces? 2 ☐ No		If Yes, specify (	Cuban, Mex	xican, Puerto	ecify Yes or No- Rican, etc.)	Blac	ck, White,	
3	urs a	by	3 Widowed 4 Divorced	If Yes, G Year or I	IVE	50-51	1☐Yes 2🂢	No Spec	cify:		Specif	BLA	CK
21215-0036	72 hours "natural",	Completed	15. Decedent's I (Specify only highest g		1	16a. Dece	dent's Usual Oc	cupation	most of worki	ina	16b. Kind of B		
7	d within 72 ho plene. r than "natu Ine Medical	nple	Elementary/Secondary (0-12)		1-4or 5+)	life.	kind of work do DO NOT use re	tired)	most of work	ng			
	il Hygien other th	Co	10			CRA	ANE OPE				BETHLE		TEEL
ב	be fill ital H id ott	Be	17. Father's Name (First, Middle, Las	t)						(First, Middle,	Maiden Suman	1ө)	
$\frac{8}{5}$	Mer Mer arka	은	BRUCE RATHER						ELACY				
Maryland	12 ha 7 is		19a. Informant's Name/Relationship OLLIE L. RATHER/				ng Address (Str PENROS)			al Route Numbe		State, Zip 21223	
	s 1 and f Health itam 27 othar ti	;	20a. Method of Disposition		20	b. Place of Dispo			-	Date	20c. Location -		
Baltimore,	m O		1 X Burial 2 ☐ Cremation 3 i		State	cemetery, crei	matory or other	place)	1	3-2004	VICTOR	-	
			' 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		1		2. Name and Ad		4.				
n	permit. Departr Imports any inju		Jam 0	07	20 t				JAM				F.H., INC.
			23a. Part1 Inter the disease, or cor shock, or heart failure. List only	nplications that	caused the c					BALT  or respiratory and		<u>MD</u> 2	21217 Approximate
	Physician		Immediate Cause (Final	one cause on	Lan	1 1	/	//	mce				Interval Between Opset and Death
1	/Medical		disease or condition resulting in death)	a. Due to		sequence of):	Lung	1-6					197
	Examiner			b		. , ,						ĺ	
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		(or as a con	sequence of):			-				
	nd transi	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	C									
Š,	e exe	EX	resulting in death) Last	Due to	(or as a con	sequence of):							
8/60	cate be executed physician and the burial-transit	dlcal	•	d									
٥	ding p	/Me	IF FEMALE:	020 15 100 01	toomo of					-			
X Q Q	death certifi e attending id for use as	cian/Me	23b. Was decedent pregnant in the past 12 months?		birth 2 🗆 F	etal death 3	Ectopic pregna				23d. Dat	e of delive	ry Day Year
j	v requires that the death certifi been signed by the atlending should be detached for use as	Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr	nant at time	or death 5L	Other (specify	)					
ī.	requires that the leen signed by th hould be detache	/ Ph	Part II. Other significant conditions	contributing to d	leath but not	resulting in the u	nderlying cause	given in Pa	art I.	23e. Did to	bacco use conti	ribute to th	e cause of death?
dS	luires n sign lld be	d by								1 🗆 Y	es 2 🗆 No	3 🗌 Proba	ably 4 Unknown
COL	law requir as been si 2 should I	lete								24a. Was a	n 24h V	Vere autor	sy findings available
Ĕ	0 4 0	ompleted								autops perfori	ned?	rior to con leath?	npletion of cause of
VII	ilcian: Th certificate rector, pag	Ö	25. Was case referred to medical					26 PI	lace of Death	1 Yes		∐ Yes	2 No
	S 0 T	0 8	examiner?	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA	Othor	Nursing Hor	S 1		er (Specify	)
0	iding Physith. Ih. After this funeral di	T:u	27. Manner of Death	28a. Date	of Injury th, Day Year	28b. Time of	28c. lr	njury at Nork?		28d. Describe ho			
VISION	Attending r death. actor: After by the fune	atlo	1 Natural 5 Pending 2 Accident Investigation	on	,,	, mary		Yes 2	2 □ No				
Š	r Att ter de iracte	ertification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	28e. Place	of Injury - A	kt home, farm, str	eet, factory, offi	ce	2	28f. Location (Si City or Town		er or Rural	Route Number,
2	urs af ral D	O											
	Hosp 24 hou Funa tely fi	edical	29a. Certifier Certifying P (Check only one)	miner: On the b	asis of exam	knowledge, death nination and/or inv	occurred at the vestigation, in m	e time, date ny opinion, d	e and place, a death occurre	and due to the ca ed at the time, d	ause(s) and ma ate and place, a	nner as sta ind due to	ited. the cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Mec	29b. Signature and tile of certifier	and man	ner stated.	3	29c. Lice	ense numb	oer	2	9d. Date signed	(Month. D	Dav. Year) .
	F 3 F 0		1 13.11	Laine	ben	MD		018	587	<	EDT	9 7	on4
	180		30 Name and address of person who	gompleted cau	se of death (	Item 23a) (Type,	Print) /				1	1,2	/
_	, f,		Paul Gorm	ley	400	Coto	n Au	2 1	Selt	mi	) 2	122	9
	Sta		31. Date filed (Month, Day, Year)	32. F	egistrar's Si	gnature							/
	Registr	ar	OF1 - 0 500	1	NU L	A ADDA	a.						

				1 - State State Registrer	te of Ma	-	•	of Health and N		200 L	28833
				Decedent's Name (First, Middle, Last)			Scrimoato	Or Death	Reg. 2. Date of Death		3. Time of Death
		Physici /Medio		Cynthia	ī. u	cille		Rice	September		104 2:54 AM
		Examin		4a. Facility Name (If not institution, give street a	and number)	)	4b. City, T	own, or Location of Death		4c. County of	Death
				5. Social Security Number 6. Sex	MUTI	(In yrs. last birth	day) If Under 1	Year If Under 24 Hrs.	8. Date of Birth		Bill I Give 5
		Funeral Director		1 □ M 2	EXF 7. Age	, ,		Days Hours Min.	(Month, Day, Ye	ar)	Birthplace (State or Foreign Country)
				Usual Residence of Decedent					10 23	48	MD
		ehow	2	10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
		the M	Director	MD NA  10e. Street and Number		Baltim	ore	^ode	100	Citizen of Wha	1 X Yes 2 No
		3a or	Ö				101. Zip C		109.		
		after death with the Marylan or Iteme 23a or 28a-f ehow culter cust be natilled at	Funeral	4014 Boarman Ave	s Decedent E	ver in U.S.	13. Was Decede	21215 nt of Hispanic Origin? (Sp y Cuban, Mexican, Puerto	pecify Yes or No-		American Indian,
5	36	or Ite		1 Never Married 2 Married 1	Yes 2 N es, Give	0	1 ☐ Yes 24		nicari, etc.)	Specify:	White, etc. Black
SUN,	9	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Iteme 23a or 28a-f ehow int, the Modical Exe. unger vust be mailled as	Completed by	3 ☐ Widowed 4 🕅 Divorced Ÿe.	ar or Dates:	160.	Decedent's Usual		466		
3	215	in 72 n "na	piet	(Specify only highest grade comp			Give kind of work life. DO NOT use	done during most of work retired)	king	. Kind of Busin John	Hopkins
2	212	filed with Hygiene. other ther	E		llege (1-4or 5- 7 <b>13</b>		bstance	Abuse Co	unselor		-
=	pu	be filed wintal Hygien of other the event, It is	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Maid	den Sumame)	
Lucille	₹	should be and Mental is marked c	2	William Rice Sr.  19a. Informant's Name/Relationship (Type, Pri				Agnes H			·
Cynthia	Maryland	d 2 7 Is		William Rice JrB				Street and Number or Rui			727212
2		nit. Pages 1 and 2 artment of Health or ortent: If item 27 I Injury or other tre 8.	1 3	20a. Method of Disposition	rocne		14 BOAK Disposition (Name crematory or oth	man Ave,	Baltinor Date 20c		y or Town, State
Z	E	Pages nent of I ont: If its ury or o		1 Burial 2 □ Cremation 3 □ Remova  '4 □ Donation 5 □ Other (Specify)	I from State			rial Park	9/13/04	Λrhut	na Ma
-3	Baltimore,	permit. Page Department of Importent: If any Injury or once.		21. Signature of Funeral Service Licensee	V	1	22. Name and	Address of Facility	J/ 13/04	ALDUL	.us, Mu
	<u>m</u>	82 5 8	1	Duymo D.	Te	ke	4300 W	F/H West Jabash Ave	Baltime	ore. M	d 21215
	т			23a. Part1. Enter the disease, or complications shock, or heart value. List only one cause	that caused e on each lin	the death. Do no	t enter the mode	of dying, such as cardiac	or respiratory arrest,	12.0	Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition resulting in death)	Sever	e sep	SIS				Gnset and Death
		/Medical Examiner		Comming an assum,	oue to (or as a	consequence of	):				1
			er	Sequentially list conditions, bb.	ue to (or as a	consequence of	).				
		cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to unimediate cause. Enter Underlying Cause (Disease or Injury that initiated events							
	0,	cate be executed obysician and the burial-transit		resulting in death) Last	ue to (or as a	consequence of	):				
	8760,	cate ohy: the	dical	d							
	9		/Me	IF FEMALE: 23c. If v	es, outcome d	of pregnancy				224 P-1-	a de la Colonia
	Box	atten d for u	Physician/Me	in the past 12 months?		2 Fetal death	3 ☐ Ectopic preg			23d. Date of Month	Day Year
	P.O.	that the deathed by the atte	hysi	9 Unknown	Unknown						
		es tha igned be det	by P	Part II. Other significant conditions contributing		t not resulting in t	he underlying cau	se given in Part I.	23e. Did tobacc	o use contribu	te to the cause of death?
$\searrow$	ord	w requir been si should	ted	CILLVORD OF IM	er_	·	······		1 Tes	2□No 3□	Probably 4 Unknown
6	Records,	e law r has be	Completed	Hepatitis C				<del></del>	24a. Was an autopsy	prior	e autopsy findings available to completion of cause of
	alF	ician: The l certificate ha ector, page		`					performed 1 ☐ Yes 2 ☐		n? Yes 2□No
	Division of Vital	ding Physician: h. After this certific funeral director.	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital	1 Inpatier	- 2□EB/0		Other	h (Check only one)	a 🗆 🗆	
	o	g Physier this	n; To	27. Manner of Death 28a.	Date of Injury (Month, Day	28b. Tir	ne of 28d	: Injury at	ome 5 Residence 28d. Describe how in		Specify)
	ior	Attendin death. ctor: Aft y the fun	Certification:	1 Vatural 5 ☐ Pending 2 ☐ Accident investigation	(Mortui, Day	rear/ inj	M M	Work? 1 ☐ Yes 2 ☐ No			
	Ξ	or Att	rtific	3 Suicide 6 Could not be determined 28e.	Place of Inju building, etc.	ry - At home, farm . (Specify)	n, street, factory, o	office	28f. Location (Street City or Town, St	and Number o ate)	r Rural Route Number,
		pitel o		29a. Certifier 1 Certifying Physician:	To the book		d- all				
		To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edicai	(Check only 2 Medical Examiner: Or	the basis of d manner stat	examination and/	death occurred at or investigation, in	the time, date and place, my opinion, death occur	and due to the cause red at the time, date a	o(s) and manne and place, and	r as stated. due to the cause(s)
		To the within To the comple	Me	29b. Signature and title of certifier	4.		29c. l	icense number	29d. I	Date signed (N	lonth, Day, Year)
		1		Kennan Ma	ner	0.0.	R	ES-OOD		sept.	8,2004
		9		30. Name and address of person who complete	d cause of de	ath (Item 23a) (T	ype, Print)	1 .10	c Q. 11	. 0	
				31. Date filed (Month, Day, Year)	32 Aprietro	r's Signatude	nai	105/100	of PUNITIN	noke	)
		Sta Registr		SFP 1 0 2004	J. Aleka		speciel	·			

State of Maryland / Department of Health and Mental Hygiene

				State of Marylar	•	tificate of			eg. No.	04 3	28834
	<b>D</b>	_	1. Decedent's Name (First, Middle, Last)					2. Date of Deat		Year	3. Time of Death
-	Physiciar /Medica	al L	Catherine	N.		Readmon		Month 09/04/	2004	1001	3:55 A
) <u>.</u>	Examine	-	4a Facility Name (If not institution, give s Charles County Nur		. Cente		4b. City, Town, or L LaPlata	ocetion of Death.	4c. County Char		
	Funeral Director		5. Social Security Number 6. Sex 213-38-1784	7. Age (In yrs.	lest birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth Month Day 07/27/1	Year) 914	Country	gton, DC
	Du .		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ty, Town or Loc	ration				10d	. Inside City Limits
	e Maryle	ctor	Maryland Prince Ge		Clinton					100	1 ☐ Yes 2x(∑) N/o
	vith th		10e. Street and Number			10f. Zip Code		1	0g. Citizen of \	What Country	?
	eath re 23	era	5801 Spell Road	12. Was Decedent Ever in U	JS 13 W	207		pecify Yes or No-	14. Rac	USA e - American	Indian.
020	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Deformation the Consultant of the Consultant	Completed by Funeral Director	1 Never Married 2 Married  ★ Married 4 Divorced	Armed Forces? 1 □ Yes 圣色 No If Yes, Give Year or Dates:		Yes, specify Cub ☐ Yes ※2 ※ No	Hispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)	Blac	ck, White, etc /: White	
5-0	72 ho	ered	15. Decedent's Educ (Specify only highest grede	etion completed)	16a. Decede	ent's Usual Occup	pation during most of world)	kina	16b. Kind of B		itry
121	within ene. than	E C	Elementary/Secondary (0-12)	College (1-4or 5+) ∠.	Teacl		d)		P.G. Co School		m
bi	other officer,	S -	17. Father's Name (First, Middle, Last)		i			ne (First, Middle, M			
ylaı	Menta Menta	9	Harvey S. Naylor				Inez E	E. Allen			
Mar	le she is ma raum		19a. Informant's Name/Relationship (Ty)				and Number or Ru		-		ode)
e,	1 and Health em 27	-	Kathryn Donato /			SPELL KO ition (Neme of etory or other pla	ad Clinto		and 20c. Location -	20735 City or Town	. State
ē	Peges nent of h ant: If ite ury or of		1 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	e <i>ton</i> y or other pla 1 Cemete		9/10/200	4 Suit	land. 1	Marvland
Baltimore, Maryland 21215-0020	permit. I Departm importar any inju		21. Signature of Typeral Service License		22.	Name and Addre	escripe F Hill Road	. Kalas	Funeral	I Home	PA
	TAX UNITS	1	23a. Part 1. Dier ve disease, or com li- shock, ve he in failure. List only on	cations that caused the deat						A	pproximate
	Physician /Medical Examiner		shock, or helint failure. List only on  Immediate Cause (Final disease or condition resulting in death)	Sep	2515				v	in O	terval Between nset and Death
			resulting in death)		1					1	
	executed in end inel-trensit		Sequentially list conditions	. Term	or as a consequ	PACE OFF	moni	O(		-	
0,	e exec	Ĭ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.								
68760,	rificete be executed og physician end es the buriel-trensit	200	that initiated events resulting in death) Last	Due to (o	or as a consequ	ence of):					
οχ θ		/Me	L a								
. Box	death cert e ettendin d for use		Part II. Other algnificant conditions con	tributing to death but not res	sulting in the un	derlying cause giv	ven in Part I	23b. Did to	bacco use co	ntribute to th	e cause of death?
P.O.	that the death certing the bettending deteched for use e Vertical All		an in other argument conditions	induling to down but not los	Jaking III the an	donying oddao ga	voiriiri aivi.		s 2 No	3 Probat	\/
Records,	requires been sign should be	neted by						24a. Was a		availa	autopsy findings ible prior to letion of cause ath?
Re	0 - 2 -							1UYe	e 2)K(110	1□Y	′es 2.⊠No
Vital	certificate rector, peg		25. Was case referred to medical				26. Place of Dea	th (Check only on	9)	1	
of <	S S S S S S S S S S S S S S S S S S S	Pospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Hom									
uc.	h. After t funer		27. Manner of Death  1 Natural 5 ☐ Pending 2	28d. Describe ho	w injury occur	red					
Division	27. Manner of Death   X Natural   5   Pending investigation							28f. Location (St. City or Town		er or Rural R	oute Number,
_	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by Marlical Certiff	Calcal	29a. Certifier (Check only one) (Check only one) (2 ☐ Medical Examin	iclan: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation end/or inve	occurred at the tirestigation, in my c	me, date and place opinion, death occur	and due to the ca red at the time, da	use(s) end ma ite and place,	inner as state and due to th	od. e cause(s)
	within 2		29b. Signature and title of certifier	and mailler stated.		29c. Licens	se number	25	d. Date signe	d (Month, Da	y, Year)
	/		> Yallune	MI	$\bigcirc$	00	5545	5	7/4/1	74/	
	16		30. Name and eddress of person who con	mpleted cause of death (Iter	m 23a) (Type, P	rint)	, , , ,		1/0/0		
	17		Fatima Y. Hu	SSEID, 562	25 AI	lenteu	in Rd.	, Suit	e 101	, Suit	cland, MD
	State		SEP 10 200	320 legistrar's Signa	ature						

DHMH 16 Rev 6/95

			riea	State of Mar					•	ne.	
			For State Registrar	State of Ivial	•	rtificate of L			Reg. No.	1 28	935
			Decedent's Name (First, Middle	, Last)				2. Date of Dea	ıth		ne of Death
	Physici /Medic		Hoyt Gle	nn Rot	erts			Septem !	per 7	Year 2004	3:40PM
	Examin		4a. Facility Name (If not institution	, give street and number)	à	4b. City, Town, or	Location of Death		4c. County of	f Death	
				ospital Cen		Kanda	Istowi		Balti		
	Funeral		5. Social Security Number	6. Sex 7. Age (	In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		Birthplace (Sta Country)	ite or Foreign
	Director		459-12-8978 Usual Residence of Decedent	Λ 00	J 113.			Nov 7,	1917	Texas	
vland	Mo to		10a. State 10b. County	1	0c. City, Town or L	ocation				10d. Insid	le City Limits
Mar	a-is Daill	ctor	Maryland Baltin	nore	Windsor	Mill				1 🗆 '	Yes 2∏ No
E E	or 28	Olre	10e. Street and Number			10f. Zip Code			10g. Citizen of W	nat Country?	
ath w	1 23a	Funeral Director	2 Valdivia Court			21244-				States	
er de	Items Der 1	nne	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	<ul> <li>American Indian</li> <li>White, etc.</li> </ul>	n,
<b>.0036</b> hours after death with the Maryland	rai', or items 23a or 28a-f show Extrainer rust be notified at	by F	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	ed 1 Tyes 2 No If Yes, Give Year or Dates:		1☐ Yes 2∑ No	Specify:		Specify:	White	
21215-0036 d within 72 hours at	"natural", or Items	Completed by	15. Decedent	's Education	16a. Dece	edent's Usual Occupa	ition		16b. Kind of Bus	iness/Industry	
1215 within 7		ple	(Specify only highes Elementary/Secondary (0-12)	Coilege (1-4or 5+)	life.	kind of work done d DO NOT use retired,	uring most of work	ing	automob	ile reta	ail
	I Hygiene other than /ent, the M	Con	12	0		salesman	· · · · · · · · · · · · · · · · · · ·				
ind ind	od oth	Be	17. Father's Name (First, Middle, I	_ast)			18. Mother's Name	,	Maiden Sumame	)	
Maryland	nd Menta marked matic ev	٢	S.M. Roberts  19a. Informant's Name/Relationsh	sin (Time Deint)	106 144	ing Address (Street a	Delia A	-	. C.t T	7. O. 41	
Ma	th and 7 is m traum		JoAnn Pfeiffer -	,		4 Kensingt					21229
<b>e</b> -	Hear tem other		20a. Method of Disposition		20b. Place of Disp	osition (Name of	1	Date		City or Town, State	
HO Page	ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from State	Meadowri	matory or other place dge Cemete	gry Sept	ember	Elkrida	e, Maryl	and
Baltimore,	Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M ODCe.		21. Signature of Funeral Service I		2	2. Name and Addres				me, Inc.	
<u> </u>	Depa Impo any i		Ichn y.	sink	4	107 Wilker					
			23a. Part1. Enter the dise se, or shock, or heart failure. List	comclications that caused the						Approxi Interval	imate Between
	hysician		Immediate Cause (Final disease or condition	Multiple	organ s	system fo	vilure			1 2 1	a.V.S
	Medical xaminer		resulting in death)	Due to ( as a c	consequer ce of):	, L		1			1,
1	Adminici	<u>.</u>	Sequentially list conditions,	b. Systemic		malory	response	synd	rome	>9m	eeks
7 7 79	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Bilator		0/1mmn : 0	Carl	· · · · · · · · · · · · · · · · · · ·	(1)	211	
, ,	n and al-tra	Exar	that initiated events resulting in death) Last	Due to (or as a	consequence of):	eumon 19	- poly	MICLOR		200	rys
760,	ed by the attending physician and detached for use as the burial-transit	call		d							
68 tificat	ng ph) as th	<b>l</b> edi	IS ESAME								
Box eath cert	lendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		□Ectopic pregnancy				of delivery	
O. E.	the att	sicl	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at tin		Other (specify)			Mont	h Day	Year
P.O.	d by l	Phy	Part II. Other significent condition	Rs contributing to death but	not resulting in the	Inderhina cause awa	n in Part I	23a Did to	hacco usa contrib	oute to the cause	of death?
Records, P.O. Box 68 The law requires that the death certifical	s been signed b	Completed by Physiclan/Med	left oneumothe	way // Chros	- 1 d	11 4 1 2 1	1.	64.5% 10Y	. /	B Probably 4	
JOS N	been	lete	D. Lates mall	tus 11 Page	symal at		Hatan	24a. Was a	24h W	ere autopsy findir	age available
R e	e has	dmo	C- L I	1197	TI I was a	TICH DOL	THMITOLI	autop: perfor	sy pri med?/ de	ior to completion ath?	of cause of
		a)	25. Was case referred to medical	ar disease	Anonin	V.	26. Place of Deati			Yes 2□No	
of Vita Physician:	this cer al direc	To B	examiner? 1 □ Yes 2 <b>V</b> No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Othe	P.		ence 6 🗍 Other	(Specify)	
0 4	T. After th funeral	:uc	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	(ear) 28b. Time (	of 28c. Injury Work		28d. Describe h	ow injury occurre	1	
Vision	death. ctor: A y the fu	catio	2 Accident investig	jation			'es 2 □ No				
Division of	olrect Direct in by	Certification:	4 Homicide determine		r - At home, farm, si (Specify)	reet, factory, office		28f. Location (S City or Tow		or Rural Route N	√umber,
pitai	ours a	Ce	29a. Certifier 1 Certifyin	g Physician: To the best of	my knowledge dea	th occurred at the tim	e date and place	and due to the o	ausa(s) and man	nor as stated	
DIV	within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical		Examiner: On the basis of examiner state	kamination and/or in	vestigation, in my op	inion, death occurr	ed at the time, o	late and place, ar	d due to the caus	se(s)
To th	within 24 hours after death To the Funeral Director: completely filled in by the t	Me	29b. Signature and title of certific	110		29c. License	number	2	29d. Date signed	(Month, Day, Yea	r)
			\$ 1500lo	M MD		Da	8462	S	eptembe	r 7, 20	204
,	<b>ω</b> 1.1Δ	. !	30. Name and ad ress of person	who completed cause of dea	th (Item 23a) (Type		+ 0	. 1 11	· · ·	A4 .1	1
6	TIVA		31. Date filed (Month, Day, Year)	Northwe 32. Registrar	ST HOS	Ditail Ler	ner K	andall	stown,	Maryl	ind
	Sta Registr		CFD 1 0		July 1	for 1	,		•	1	

DHMH 17 Rev 1/2001

ORIGINAL.

	ian	1. Decedent's Nam Mary El		. ,	an							2. Date of Month		Day	Year		of Deat
/Medi	cal	4a. Facility Name				ner)	···	4h City	Town or	Location of	of Doath	Aug.		40. Com	2004 Inty of Death	3:00	_P
Exami	ner	Maples		-	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,0,,			wson		or Dodui				timore		
ıneral		5. Social Security		6. Sex		Age (In yrs	s. last birthday		r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of	Birth Day, Ye			place (Stat untry)	e or Fore
rector		214-46-		1	M 2 F	94	Yrs.	Month	Days	riouro		Dec.	8 1	909		wa	
Mo #		Usual Residence of 10a. State	10b. County	/		10c. C	ity, Town or L	ocation							Т	10d. Inside	City Lin
등	ţ	MD	Baltin	more	:	-	Timoni	um								1 □ Y	es 2🕱
or 28s	Director	10e. Street and Nu	umber					10f. Zip	Code				10g.	Citizen	of What Cou	intry?	
23e	ral	205 Brig	ghtdale	Roa	ad				2109	3				USA	<b>A</b>		
ltems Darin	Funeral	11. Marital Status		1:	<ol><li>Was Deceded Armed Force</li></ol>	es?	U.S. 13.	Was Deced	dent of Hi cify Cuba	ispanic Ori In, Mexicar	igin? (Sp n, Puerto	ecify Yes or Rican, etc.)	No-		Race - Amer Black, White		
P E	by F	1 ☐ Never Mar 3√2 Widowed	Tied 2∐ Mar 4 ∏Divorced		1 ☐ Yes 2 If Yes, Give Year or Date			1 🗆 Yes	2 <b>√</b> №	Specify:				Spec	cify: W	hite	
ical E	ted		15. Deceder	nt's Educ			16a. Dece	edent's Usua	al Occupa	ation	A = 6= w		16b	. Kind of	f Business/I	ndustry	
- Med	Completed	Elementary/Sec	orify only higher ondary (0-12)	st grade	Completed) College (1-4	or 5+)	life.	DO NOT us	ise retired	uring mos	it or work	ang					
is marked other then eumatic event, the M		12	/F* 14*	( 1)	n/a		Hom	emake	er	40.14.11				•	Home		
item 27 is marked other then "neturel", or items 23e or 28a-f show other treumatic event, the Medical Examiner must be notified at	Be	17. Father's Name  John St		, Last)								e (First, Mid Elizab					
mark	2	19a. Informant's N		ship (Tvp	e. Print)		19b. Mail	ina Address	S (Street a			al Route Nu				n Code)	
27 is r treu		Michael			-, · · · · · · ,							Arlin		•			
othe	13	20a. Method of Dis	sposition				Place of Disp	osition (Nar	me of		9/4/	Date			n - City or T		
Department of Health Importent: If item 27 any injury or other tr. 900.0.	Н	1 XBurial 2 1 Donation			moval from St	ate D	ulaney	-					าร	Tin	noniu	m, ME	)
		21 Sippers, of F	m W.	Clary	and		L	2. Name an emmor 10 W.	nd Address n Fu Pad	s of Facilit neral	Hoi	me_of , Tim	Dul oniu	aney	/ Vall	ey, li	nc.
		23a. F rt1. Ente	the disease, o	r complic		sed the dea	ath. Do not en	iter the mod	de of dying	g, such as	cardiac	or respirator	y arrest,			Approxim Interval B	ate
sician		Immed te ase disease conditi		,	A		h /		- 1/-	,					- 1.	Onset an	
edical		consisting in donah					Fire I has P	ルレス	12	mp	2017	A			1		
minor		resulting in death)	)		Due to (or	as a conse		NU 5	DE	me	wn	A			1		
miner				<b>S</b> b.		as a conse	quence of):	2015	DE	ne	wN	A					
	niner	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease of	onditions, mmediate erlying r injury	<b>\biggrey</b> 5.			quence of):	nu 5	DE	nie	wn	A					
	Examiner	Sequentially list or	onditions, mmediate lerlying r injury ts	6.	Due to (or	as a conse	quence of):	nu s	DE	ne	N	A					
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hysician and the burial-transit	Examin	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)	onditions, mmediate lerlying r injury ts	₹	Due to (or	as a conse	quence of):	ws	De	ne		A					
hysician and the burial-transit	Examin	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)  IF FEMALE: 23b. Was deceder	onditions, mmediate erlying r injury is Last	c.	Due to (or  Due to (or  Due to (or  Lives, outco	as a consection as a consectin as a consection as a consection as a consection as a consection	quence of):  quence of):  quence of):  anancy all death 3	⊐∈ctopic pr	regnancy	ne	w 17	A			Date of deliv		Year
attending physician and for use as the burial-transit	Examin	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)  IF FEMALE:	onditions, mmediate erlying is is Last  ant pregnant 2 months?	c.	Due to (or Due to (or conditions)	as a conse	quence of):  quence of):  quence of):  anancy all death 3		regnancy	ne		A				ery Day	Year
ed by the attending physician and detached for use as the burial-transit	Physician/Medical Examin	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2.	onditions, mediate erfying rinjury is Last	d.	Due to (or  Due to (or  Due to (or  lc. If yes, outco 1	as a conse	quence of):  quence of):  quence of):  anncy tal death 3i death 5i	⊒∈ctopic pr ⊒ Other (sp	regnancy				d tobacc	٨		Day	
gned by the attending physician and be detached for use as the burial-transit	by Physician/Medical Examin	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1  Yes 2 9  Unknown	onditions, mediate erfying rinjury is Last	d.	Due to (or  Due to (or  Due to (or  lc. If yes, outco 1	as a conse	quence of):  quence of):  quence of):  anncy tal death 3i death 5i	⊒∈ctopic pr ⊒ Other (sp	regnancy			23e. D	id tobacc	٨	Month ontribute to t	Day	f death?
been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Medical Examin	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1  Yes 2 9  Unknown	onditions, mediate erfying rinjury is Last	d.	Due to (or  Due to (or  Due to (or  lc. If yes, outco 1	as a conse	quence of):  quence of):  quence of):  anncy tal death 3i death 5i	⊒∈ctopic pr ⊒ Other (sp	regnancy			23e. D 11	□ Yes tas an	co use co	ontribute to t	Day the cause of bably 4 [	f death?  Unkno
e has been signed by the attending physician and age 2 should be detached for use as the burial-transit	by Physician/Medical Examin	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1  Yes 2 9  Unknown	onditions, mediate erfying rinjury is Last	d.	Due to (or  Due to (or  Due to (or  lc. If yes, outco 1	as a conse	quence of):  quence of):  quence of):  anncy tal death 3i death 5i	⊒∈ctopic pr ⊒ Other (sp	regnancy			23e. D 1 24a. W	Yes as an atopsy orformed	co use co	ontribute to t  3 Prol  D. Were auto prior to co death?	Day the cause of bably 4 [	f death?
tificate has been signed by the attending physician and for, page 2 should be detached for use as the burial-transit	e Completed by Physician/Medical Examin	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1	onditions, mmediate leftying rights is Last  ht pregnant 2 months?	c. d. 23	Due to (or  Due to (or  C. If yes, outco 1  Live birth 4 Pregnan 9  Unknow	as a conse	quence of):  quence of):  quence of):  anncy tal death 3i death 5i	⊒∈ctopic pr ⊒ Other (sp	regnancy	an in Part I.		23e. D	Yes  tas an itopsy orformed	co use co	ontribute to t  3 Prol  D. Were auto prior to co death?	Day the cause of bably 4 [	f death?
is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examin	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1	onditions, mmediate ertying r injury ts Last  nt pregnant 2 months?  Initiant conditi	c. d. 23	Due to (or  Due to (or  Due to (or  1 Live birth 4 Pregnar 9 Unknow  cributing to deal	as a conse	quence of):  quence of):  quence of):  nancy al death 3 ideath 5 i	□Ectopic pr □ Other (sp underlying c	regnancy pecify) eause give	an in Part I. 26. Place <sup>27.</sup> 4.⊟Nü	e of Death	23e. D 11 24a. W au pe 1	Yes  tas an attopsy offormed as Y and a sidence	24b	ontribute to to 3 Prol	Day the cause of bably 4 popsy finding impletion of 2 No	f death'
this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examin	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1	onditions, mmediate leftying r injury ss Last  Int pregnant c months? Initiation ificant conditi	c. d. 23	Due to (or  Due to (or  Due to (or    Due to	as a conse	quence of):  quence of):  quence of):  nancy al death 3 ideath 5 i	□Ectopic pr □ Other (sp underlying c	regnancy pecify)  ause give	26. Place  26. Place  31: 4∠1Nu	e of Death	23e. D 11 24a. W at pe 1	Yes  tas an attopsy offormed as Y and a sidence	24b	ontribute to to 3 Prol	Day the cause of bably 4 popsy finding impletion of 2 No	f death?
for: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examin	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1	onditions, mmediate ertying ritying int pregnant 2 months?  Mo ifficant conditi investi 6   Could	c. d. 23 cont Ho	Due to (or  Due to (or    Due	as a consect as a	quence of):  quence of):  quence of):  quence of):  anancy al death 3 ideath 5 ideat	□Ectopic pr □ Other (sp underlying c  ant 3□ DC of 2 M	regnancy pecify)	26. Place	o of Death	23e. D 11 24a. W au 11 Ye 1 (Check on me 5  R 28d. Descrit	Yes  tas an  stopsy orformed  s Y   esidence  be how in	oo use co	ontribute to t  3 □ Prol  D. Were autoprior to death? 1 □ Yes  Other (Special curred)	Day  the cause of bably 4 [  popsy finding impletion of 2   No	f death?  Unkno
for: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examin	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1	onditions, mmediate erlying r injury is Last  nt pregnant 2 months?  no ificant conditi  irred to medica	c. d. 23 cont Ho	Due to (or  Due to (or  Due to (or    Live birth   Pregnar   9 Unknow   Unknow   Unknow     Despital: 1   Inp.     28a. Date of (Month,	as a consect as a	quence of):  quence of):  quence of):  quence of):  ancy tal death 3 ideath 5 ideath	□Ectopic pr □ Other (sp underlying c  ant 3□ DC of 2 M	regnancy pecify)	26. Place  26. Place  31: 4∠1Nu	o of Death	23e. D  1  24a. W au pe 1  Ye n (Check on me 5  R 28d. Descrit	Yes  tas an  stopsy orformed  s Y   esidence  be how in	No 24b	ontribute to t  3 □ Prol  D. Were autoprior to death? 1 □ Yes  Other (Special curred)	Day  the cause of bably 4 [  popsy finding impletion of 2   No	f death?  Unkno s availa cause (
Funerel Director: After this certilicate has been signed by the attending physician and ely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical Examin	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1	onditions, mmediate ertying rights int pregnant 2 months? Mo niticant conditi investi 6   Could detem	c. d. 23 ions cont	Due to (or  Due to (or  Due to (or  Lic. If yes, outco 1	as a consect as a	quence of):  quence of):  quence of):  quence of):  quence of):  ancy al death 3 i death 5 i sulting in the i 28b. Time o Injury  nome, farm, st ify)	DEctopic pr Other (sp  underlying c  nt 3 DC  M  treet, factory	regnancy pecify)  Pause give	26. Place ar: 4. Nu at ?? Yes 2 □ I	e of Death	23e. D  11  24a. W au pe 1  Ye h (Check on me 5  Ri 28d. Descrit 28f. Location City or	Yes  tas an attopsy offermed as an attopsy offermed as an attopsy offermed as a second and a second a second and a second and a second and a second and a second	No 24b	ontribute to t  3 □ Prol  D. Were autorior to codeath? 1 □ Yes  Other (Special Control of the Co	Day  the cause of bably 4 [  posy finding projection of 2 No  No  All Route Number 1 and	death? Unkno s availa cause
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			State of Maryland / Depar State of Maryland / Certif		ental Hygi	•	
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last) Elizabeth H.  4a. Facility Name (If not institution, give street and number)	Reid  4b. City, Town, or Location of Death	2. Date of Death Month August	31, 2004 3. Time of Death  4c. County of Death	
	Examin Funeral Director	er	Mercy Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 212-03-2881 1□ M 2☒F 86 Yrs.	Baltimore  If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Aug 17,	9. Birthplace (State or Foreign Country)	
	r 28a-f show	rector	Usual Residence of Decedent   10a. State		10	10d. Inside City Limits 1 ☐ Yes Z∑ No  10g. Citizen of What Country?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28a-1 show any figury or other traumatic event, the Medical Evantinal reliable and once.	by Funeral Director	1 Never Married 2 Married 1 Yes 2 ZANo	21212 as Decedent of Hispanic Origin? (Spe yes, specify Cuban, Mexican, Puerto □ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: white	
Maryland 21215-0036	d within 72 hou giene. er then "natural , the Medical E	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	nt's Usual Occupation nd of work done during most of worki O NOT use retired) Waitress	ng	6b. Kind of Business/Industry	
aryland	should be file and Mental Hy smarked othe iumatic event	To Be (	17. Father's Name (First, Middle, Last) Alford Hurley  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	18. Mother's Name Address (Street and Number or Rura	Mary Ra	ppold	
Baltimore, M	Pages 1 and 2 nent of Health a ant: If item 27 t ary or other tra		20a. Method of Disposition 20b. Place of Disposit			#82 Balto, MD 21222 Oc. Location - City or Town, State	
■ Balti	permit. Departr Imports any inju		21 Signature of Funeral Service Licensee Renald S. Wade Virector Sta Bal  23a. Part1. Enter the disease, or complications that caused the death. Do not enter	L	W. Baltimore Street  y arrest, Approximate Interval Between		
760,	Medical Examiner and wisician and hysician a	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ructive pulme	nory o	Usepse Years	
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2	ictopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the undi			acco use contribute to the cause of death?	
Vital Records,	iician: The law r certificate has be rector, page 2 sh	Completed	grastrunterstinal bleeching  25. Was case referred to medical			prior to completion of cause of death?  No 1 Yes 2 No	
ot	ding Phys I. After this funeral di	ation: To Be	examiner?  1 Yes 2 No  Hospital: 1 npatient 2 EP/Outpatient  27. Manner of D ath 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	The state of the s		nce 6 ☐ Other (Specify)	
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	al Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, Iarm, stree building, etc. (Specify)  29a. Certifier  1 ☐ Certifying Physician: To the best of my knowledge, death of the best of the best of my knowledge, death of the best	occurred at the time, date and place, a	City or Town,	use(s) and manner as stated.	
	To the He within 24 To the Fe completel	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investand manner stated.  29b. Signature and title of certifier  What is a signature and title of certifier.	29c. License number		d. Date signed (Month, Day, Year)  Hugust 31, 260 4	
			30. Name and address of person who completed cause of death (Item 23a) Type, Pr. Nevins VV. Toka 30 ST. Taw	Place Bach	marc, n	D Z1202	
	Sta Registr		SEP 1 0 2004 Server Signature	als/			

				For Stata Registrar	State	of Marylai		epartment Certificate				-	giene Reg. No.?	nnb	288	38
				Decedent's Name (First, Middle	e, Last)							2. Date of De		Vear	3. Time of	Death
4		Physicia /Medic		MONTGOMERY	CLIFF	SMITH						SepTen		8 200	4062	7AM
	J.	Examin		4a. Facility Name (If not institution	n, give street and n	umber)	1 .	4b. City, T	own, or	Location	of Death	. /	4c. C	ounty of Dea	ith	
				UNIVERSITY	Special		tosfig	tal Di	46	imo	r 24 Hrs.	10.5		N/A		
		Funeral		5. Social Security Number	6. <b>∕</b> Sex 1 <b>X</b> OXM 2□ F	7. Mge (In yrs		nday) If Under 1 Months	Days	Hours	Min.	8. Date of Bir (Month, Da	y, Year)	0	rthplace (State or ountry)	
		Director		219-62-5974 Usual Residence of Decedent			19			L	J	APR 1	3 195	5 N	<u>IARYLAND</u>	
		anyland show		10a. State 10b. County		10c. C	ity, Town	or Location							10d. Inside Cit	y Limits
		Mar a-f st	tor	MARYLAND N/A			BALT	IMORE							1 (XYes	2 🗆 No
		or 28a-f	Director	10e. Street and Number				10f. Zip (	Code				10g. Citize	n of What C	ountry?	
7		th wi	ai C	320 E COLDSPRI	NG LANE	APT D			212					.S.A.		
8			Funeral	11. Marital Status	Armed F		U.S.	13. Was Decede If Yes, specif	ent of Hi fy Cuba	ispanic O n, Mexica	rigin? (Sp an, Puerto	ecify Yes or No Rican, etc.)	- 14	. Race - Am Black, Wh	erican Indian, ite, etc.	
n	36	s afte	y Fi	1 ☐ Never Married 2 Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes. C	2XXNo Bive		1 □ Yes 2	<b>X</b> No	Specify	<i>r</i> :		s	pecify:	7.01/	
3	8	72 hours after natural', or ite dital Examina	Completed by		nt's Education	Dates:	16a	Decedent's Usual	Occupa	ation	_		16b Kind	B1 of Busines	LACK s/Industry	
7	.15	⊆ = 3	piet	(Specify only highe	st grade completed		- 100	(Give kind of work life. DO NOT use	done o	turing mo	st of worl	king	100.11		,	
20	212	filed within Hygiene. Ither than "	mo	Elementary/Secondary (0-12) 8th grade	College	(1-4or 5+)	DI	SABLE/FO	ORKI	IFT	OPER	ATOR	AT	CO RUE	BER CO	
L	ğ	be filed ital Hygie od other event,	BeC	17. Father's Name (First, Middle,	Last)					18. Moth	ner's Nam	e (First, Middle				
1	ılan	Mental Mental arked o	To E	CLIFFORD JOHN	ISON					_R	OSAL	EE CORN	ISH			
K	ar)	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relations	ship (Type, Print)		19b.	Mailing Address (	(Street a	and Numb	ber or Ru	ral Route Numb	er, City or 1	Town, State,	Zip Code)	59
I	Σ	= N -		Venus Smith/Wif	ie			0 E Cold		ing	Lane		more,	Maryl	and 212	12
27	ore	a to to		20a. Method of Disposition  1     Burial 2 □ Cremation	3 □Removal from	- 1		Disposition (Name o, crematory or oth		Θ)		Date	20c. Loca	tion - City o	r Town, State	
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	Salt	permit. Pag Department Important: I any injury o		21. Signature of Funeral backet	thicense e			22. Name and				MMIINTTV	FIINE	RAT. HC	MF D 7	
	8	207 2 2			reour			1.						ICALL IIC	ME P.A.	
				23a. Part Enter the disease, o shock, or heart failure. List	r complications that t only one cause on	t caused the dea each line.	ath. Do n	ot enter the mode	of dyin	g, such a	s cardiac	or respiratory a	rrest,		Approximate Interval Bety Onset and D	ween
	N.	Pnysician	e w	Immediate Cause (Final disease or condition	a	ALT	35								YN	
		/Medical Examiner		resulting in death)	Due t	o (o as a conse	quence o	f):							1 01	
	П	LAdillillei	L	Sequentially list conditions,	b. —	o (or as sconse	41	75 C.							Jn.	
		bed list	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury		CAM	of To	ovry	1-1/2	ant	1				1	
		xecul and al-trar	xan	that initiated events resulting in death) Last	c	o (or as a conse	quence o	f):	-/-		14				- pv	
	8760,	be e														
	687	ficate physis the	Physician/Medical		0											
	Вох	certi nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, c	utcome of pregi	nancy	- 00-					23	d. Date of de	elivery	
	ă	death a atte	cla	in the past 12 months?	4□Pre	birth 2 Fel gnant at time of		3 □Ectopic pre 5 □ Other (spe						Month	Day Y	/ear
	P.O.	oy the	hys	9 Unknown	9□ Unl	cnown										
	رب ت	s thai	by P	Part II. Other significant conditi	ons contributing to	death but not re	sulting in	the underlying ca	use givi	en in Part	1,	23e. Did t	obacco use	contribute	to the cause of d	eath?
. \	ğ	quire en sig										10	Yes 2□	No 3□F	robably 4, 20	nknown
Ex	တ္တ	aw re s bee	ompleted									24a. Was	an	24b. Were a	utopsy findings a completion of ca	available
	R	The I	E									auto perfo	ormed? 2 No	death?	s 2□No	1230 01
	ita	ian: rtifica ctor. p	Se C	25. Was case referred to medica	ıl					26. Plac	ce of Dea	th (Check only				
10	<b>*</b>	nysic nis ce	ToB	examiner? 1 ☐ Yes 2 ☑ No			☐ ER/Out	patient 3 DO	A Oth	er: 4□N	lursing H	ome 5 ☐ Resi	dence 6	□Other (Sp	ecify)	
	0	ng Pt fter tt neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Dat (Mo	te of Injury onth, Day Year)	28b. T	ime of 28 njury	3c. Injun Worl	y at k?		28d. Describe	how injury	occurred		
	Division of Vital Records,	endir sath. or: Al	Certification:	2 Accident invest	igation			М		Yes 2[	□No					
	<u>≅</u>	or Att ter de irect	ij	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	nined 28e. Pla	ce of Injury - At Iding, etc. (Spec	home, far	m, street, factory,	office			28f. Location ( City or To	Street and wn, State)	Number or F	Rural Route Numi	ber,
		To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			- O											
		Hosp Hone Fune fely fi	ical	(Check only 2 Medica	ng Physician: To t Examiner: On the	basis of examin	nowledge nation and	, death occurred a Dor investigation,	at the tin in my o	n <i>e,</i> date a pinion, de	and place eath occu	, and due to the rred at the time,	cause(s) a date and p	nd mann <i>e</i> r a lace, and du	is stated. e to the cause(s)	)
		thin 2 the mple	Medical	one) 29b. Signature and title of certific		anner stated.		29c.	Licens	e number			29d. Date	signed (Mor	th, Day, Year)	
		N N N		PMA	Wan	10		7	) -	140	774	4	SOA	+ 81	2001	_
		1		30. Name and address of person			ew 3397 (	Type Print	هر. ر	T	1		0-1	1	7	
		1			MEHT			0 / S 01	eth	de	an	las st.	Bali	4 moi	se MD	12123
		Sta	ite	31. Date filed (Month, Day, Year	) 32	Registrar's Sign	nature	1	- 3			- ' / /				
		Regist		SED 1	0 2004	Lalues.	J.S.	week								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month **AUDREY** WALTERS SNIDER September 8, 2004 9:30P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death The Wesley Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year)

Min. (Month, Day Year)

December 6, 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 577-05-9493 87 Washington DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXXYes 2 No Directo Marvland | Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2211 West Rogers Avenue 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Nøver Married 2 ☐ Married 1 ☐ Yes XX No Specify: White Completed by XXXWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office MAnager Medical CLinic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eugene Redden Watts Minnie Ball Walters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles H Hunt Jr 15 Elphin Court # 102 Timonium, Maryland 21093 Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial XX Cremation 3 □ Removal from State GreenMount Cemetery □ Donation 5 □ Other (Specify) 9/10/04 Baltimore, Maryland ignature of Fun at S 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical **Examiner** 

**Funeral** 

Director

ir then "naturel", or items 23e or the Medical Examiner must be r

permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "naturel", or items 23e
any njury or other treumatic event, tre Medical Exercises.

Baltimore, Maryland 21215-0036

with the Maryland r 28e-f show

Examiner The law requires that the death certificate be executed the burial-transit of Vital Records, P.O. Box 68760 Completed by Physician/Medical as attending I use signed by the a peeu s certificate has b lirector, page 2 s Attending Physicien: To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, Be Certification: To

Division

shock, or heart failure. List	only one cause on each line.	i
Immediate Cause (Final disease or condition resulting in death)	a. END-STAGE DEMENTIA  Due to (or as a consequence of):	Y
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. NORMING- PRESSURE HYDROCEPHING  Due to (or as a consequence of):  c  Due to (or as a consequence of):	1245
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \times \) Yes \( 22 \) No	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death  2 Other (specify)	23d. Date of delivery Month D

Injury

28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)

23b 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CEREBROVASCULAR 25. Was case referred to medical Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of

5 Pending investigation

6 Could not be determined

1 Natural

2 ☐ Accident 3 Suicide

4 Homicide

23 <i>e</i>			ntribute to the cau	
	1 🗆 Yes	2 No	3 Probably	4 Unknow
240	1460.00	0.415	Mara suta- su G	adia a a a califab

Day

CARS

were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 No

26. Place of De	ath Check only one)
Other: Nursing h	Home 5 ☐ Residence 6 ☐ Other (Specify)
Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
fice	28f. Location (Street and Number or Rural Route Number, City or Town, State)

vledge, death occurred at the time, date and place, and due ion and/or investigation, in my opinion, death occurred at the	

29a. Certifier (Check only one)	12 Certifying Phy 2 Medical Exam	imer: On t	o the best of my know the basis of examinat manner stated.	wledge, death occu ion and/or investig	urred at the time, date and place, and due to th ation, in my opinion, death occurred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause(
29b. Signature and	d title of certifier	()	0	_	29c. License number	29d. Date signed (Month, Day, Year)

► Koher E Kohym. P. D-19425 9/9/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBYDM-D- 2211 W-ROGERS AVE-BALTO, MD. 21209 32 Registrar's gnatur

State Registrar

Medical

			1 - For State Registrar		Maryland / De		f Health and	Mental Hy	_	28840
			1. Decedent's Name (First, Middle, La	ist)				2. Date of De		3. Time of Death
	Physic		VERA PATRICIA	SNEAD				Sentem	her 7 2005	1 725 p M
	/Medi Examir		4a. Facility Name (If not institution, give		per) /	4b City, Tow	m, or Location of Deg	th	4c. County of Dea	ath
			maryland Bre	neral/	Hospital	Palti	more. (	y ful		
	Funeral		5. Social Security Number 6. S		Age (In yrs. last birthda				h 9. Bi	rthplace (State or Foreign ountry)
	Director		216-50-0075	1□M 2 <u>X</u> F	55 Yrs.	Months Da	ays Hours Min	MARCH	y, Year) 23, 1949	MD
	D		Usual Residence of Decedent						-3,1777	
	ylan		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	ith the Marylar or 28a-f show	by Funeral Director	MD		BALTIMO	RE				1 X Yes 2 ☐ No
	r 284	rec	10e. Street and Number		211212110	10f. Zip Cod	de		10g. Citizen of What C	ountry?
	3a o	0	1720 PRESSTMAN S	TREET		2	1217		USA	
	ns 2	era	11. Marital Status	12. Was Deced	ent Ever in U.S. 1		of Hispanic Origin? (S Cuban, Mexican, Pue	Specify Yes or No		erican Indian,
"	fer in	Ē	1 ☐ Never Married 2 ☑ Married	Armed Force	<b>™</b> No			rto Rican, etc.)	Black, Whi	te, etc.
93	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Date		1 ☐ Yes 2 🔀	No Specify:		Specify:	LACK
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show to Modical Examinet must be notified at	Completed	15. Decedent's E	ducation	16a. De	cedent's Usual Oc	cupation		16b. Kind of Business	
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212	with jiene r tha	Eo	12	College (1-2		JSEKEEPI	NG		CLEANING	
	iould be filed with! Mental Hygiene. Parked other than		17. Father's Name (First, Middle, Last	1)	110	JOHNHAI II		me (First, Middle,	Maiden Sumame)	
<u>a</u>	ld be ental ked c ev	To Be	LAWRENCE J. JOHNS	SON			DOROT	HY B. DA	Y	
<u>&gt;</u>	2 should and Men is marke	-	19a. Informant's Name/Relationship		19b. Ma	uling Address (Str.			r, City or Town, State,	Zin Code)
Maryland	a. a		VERNICE DAY/COUS						E, MARYLAN	
	of Health of Health item 27 i	13	20a. Method of Disposition		20b. Place of Dis	position (Name of	f !	Date	20c. Location - City or	
و	Pages nent of int: If it		1 X Burial 2 Cremation 3		ate cemetery, c	rematory or other	place)			
Baltimore,	permit. Pag Department Important: I any Injury o		* 4 □ Donation 5 □ Other (Special		Mr. ZI	ON CEMET		-14-2004		, MARYLAND
Bal	permit. Departr Importa any Inj		21. Signature of Funeral Service Lice	Mat	mi 11	22. Name and Ad				ONS F.H., INC
	402 % 0		23a. Part. Enter the disease, or com-	. The ne	70 7		LAURENS S		ALTIMORE,	MD 21217 Approximate
	Physician /Medical Examiner	iner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a	as a consequence of):	07 4.	he Lu	ing		Interval Between Onset and Death
x 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	/Medical Examiner	resulting in death) Last	d	as a consequence of):					
.O. Box	res that the death or signed by the atten be detached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown	1☐Live birt	h 2 ☐ Fétal déath : nt at time of death :	3 □Ectopic pregna 5 □ Other (specify			23d. Date of de Month	livery Day Year
Records, P.	w requires tha been signed I should be det	þ	Part II. Other significant conditions	contributing to dea	th but not resulting in the	underlying cause	given in Part I.		bacco use contribute to	o the cause of death?
al Rec		Completed			3.000.4900.79.34			24a. Was autop perfor 1  Yes	sy prior to	utopsy findings available completion of cause of 2 No
Vital	ician sertifi ector	Be	25. Was case referred to medical examiner?	Hamitali a				ath (Check only o	ne)	
of	ding Physician: h. After this certifications of the director.	은	1 □ Yes 2 XHo	Hospital: 1 Wing		BIIL 30 DOA			ence 6 □Other (Spe	cify)
ū	ding P	00	27. Manper of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of (Month,	Injury 28b. Time Day Year) 28b. Time Injury	of 28c. I	njury at Work?	28d. Describe h	ow injury occurred	
Sio	Attending r death. sctor: After y the fune	catl	a ☐ Accident investigatio			M 1	1 Tes 2 No			
Division	or Attencater death Director:	Certification:	3 Suicide 6 Could not be determined	289. Place of	Injury - At home, farm, etc. (Specify)	street, factory, offi	ice	28f. Location (S City or Tow	treet and Number or Rin, State)	ural Route Number,
	ital o	Cel								
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Pt (Check only one) Medical Exer	nysician: To the b miner: On the bas and manne	est of my knowledge, de is of examination and/or r stated.	ath occurred at the investigation, in m	e time, date and place ny opinion, death occi	e, and due to the curred at the time, c	ause(s) and manner as late and place, and due	s stated. to the cause(s)
	To T To 1	Σ	29b. Signature and title of certifier	110	T	29c. Lice	ense number	1	29d. Date signed (Mont	h, Day, Year)
)			MINST	10/10	LO.	8	4501		417184	
	2		30. Name and address of person who	completed cause	of death (Item 23a) (Typ	e, Print)	1. /	11	1 11	11
			Mabrook S.	negato	2, M.D.	111	ary/and	& Grene	ral HO	spital
	Sta Registr	- 0	31. Date fils (1901) 00. 2004	Store .	istrare signatura	W.			-	/

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1235 Year KATHLEEN SPEMES Month Physician SE 2004 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner A altimore Maryland Grenera If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Hours 212-48-040 1 M 2 7 Director Usual Residence of Deceder permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or Items 23a or 28a-f ehow any injury or other traumatic event, the Madical Francisco 10d. Inside Oity Limits 10b. County 10c. City, Town or Location 10a, State 1 les 2 No Be Completed by Funeral Director Muryland 10g. Citizen of What Country? 10e. Street and Number 1800 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) instodian Elementary/Secondary (0-12) College (1-4or 5+) 2+h Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) father 20b. Place of Disposition (Name of comptery, crematory or other Date 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Furjeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physiclan/Medical Examiner ending physicien and use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 3 Probably 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 🗆 No 2 1 Yes certificate 1 Yes Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Yes 3□ DOA 2 ER/Outpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier ATTENDING D0056948 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21217 3ALT, MORE 522 2 Marsh MO TANSINDA DULPHIN 31. Date filed (Month, Day, Year) 💋2. Registrar's Signature 1 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year <sup>™</sup>009/05/2004 **Physician** Robert Glen. Sullivan 11:00A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 12708/1934 9. Birthplace (State or Foreign New York 7. Age (In yrs. last birthday) Social Security Number **Funeral** 030-24-8259 1 ☑ M 2 ☐ F 69 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ir than "natural", or Items 23a or 28a-f shov 1 ☐ Yes 🔏 🖫 No Prince George's Oxon Hill Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 should be filed within 72 hours after death with Is and Mental Hygiene. Is marked other than "natural", or Items 23a or 2 7208 Abbington Drive 20745 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No Retired 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1973 Specify þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Budget Analyst Federal Government other traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) mit. Pages 1 and 2 should be partment of Health and Menta cortant: If item 27 Is marked injury or other traumatic av Robert G. Sullivan Jeane Roy 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dean Sullivan / Son 16101 Manning Rd. West Accokeek, Maryland 20607 20b. Place of Disposition (Name of cometery, crematory or other place)
Kalas Crematory 20c. Location - City or Town, State Date 20a. Method of Disposition 9/8/04 1 Burial 2 Keremation 3 Removal from State permit, Page Department o Important: If any injury or once. Edgewater, Maryland 5 Other (Specify) 4 Donation 22. Name and Address of Facility P. Kalas Funeral Home P.A. Funeral Service Licenses alus 6160 Oxon Hill Road Oxon Hill, Maryland 20745 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death P 11. Enter the diseare, or complication slock, or heart failure. List only one Immediate Cause (Final Parkinson's disease **Physician** EndStage disease or condition resulting in death) /Medical Due to (or as a constance of): Examiner dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a c Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of). Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 2 🗆 No detached 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Ulcer and GI Bled. Esophageal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe Renal 1 ☐ Yes 2 ☐ No hronic or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4XNursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No after death, Diractor: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Dirac 4 | Homicide Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 701 ompleted cause of death (Item 23a) (Type, Print) Prince Fredvich

DHMH 17 Rev 1/200

State Registrar

110 Hos

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O.

Suite #205

agistrar's Signature

Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 17:40 M **Physician** 04 HAROLD E. STEWART 01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ALLEGANY HOSPITAL CUM BER LAND SACRED HEART | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 27,1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral √X** M 2□ F Months 82 Director Maryland 234-26-9639 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examinar must be motified at 1 ☐ Yes 2 XNo Director Mineral Keyser 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Harley O. Staggers, Sr. Drive 26726 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. XYes 2 □ No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: lf Yes, Give Year or Dates: **WW** II 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Hardware Store & Elementary/Secondary (0-12) College (1-4or 5+) 10 Convenience Store Owner/Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be ould be fi Mental F and Mental Mary E. Taylor James E. Stewart Pages 1 and 2 should nent of Health and Men ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 88 Health i Anna V. Stewart/ Wife Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) Important: If ite, any injury or other 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Sept. 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) The Cumberland Crematory Cumberland, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Smith Funeral Home Drien Keyser, WV 26726 85 S. Main Street 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final anci **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No jo 4☐Pregnant at time of death 5 Other (specify) detached the 9☐ Unknown 9 Unknown ģ The law requires that Part II. Other significant conditions contributing to death buy not resulting in the Inderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 99 120 1 ☐ Yes 2 ☐ No 3 robably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 24 No page certificate 1 ☐ Yes 2 ☐ No Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA Certification: To 1 Tes Inpatient this Manfer of Deat Oate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Hospital or Attending after death. filled in by To the Hospital within 24 hours a To the Funeral D

> State Registrar

Medical

30. Nam

29a. Certifier

29b. Signature

(Check only

31. Date filed (Month,

and manner stated.

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

. Year

onth. Day

29d. Date signed (

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			30. Neme end eddres	1 LAKO	mpleted cause of d	eeth (Item 23	e) (Type,	Print)	HE	18595	ALE	3	9010	MO	2008	
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 234 V **Physician** RICE LINDA FATOMBOZ4, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, HOPPITAL BAITIMONE CONTER NORTHWEST 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Yrs. Director APRIL 15 1945 NEBRÁSKA 218-48-4538 59 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 77 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examination must be indiffied at 1 Yes 2 No BALTIMORE RANDALLSTOWN MARYLAND Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8605 LUGANO RD 21133 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hygiene. Int: If item 27 is markad other than "natural", or item 1 Never Married 2 Married 1 Yes 2 No Specify: BLACK þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OFFICE MANAGER DEPT OF ENERGY 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BOOKER BRYANT SUSIE BRYANT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8605 Lugano Rd., Randallstown, Md. 21133 Wanda Horne/Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or once. 4 □ Donation 5 □ Other (Specify) CEDAR HILL CEMETERY | 09-10-04 BALTIMORE, MARYLAND 21. Signature of Finance Signature 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, preaff failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOMA **Physician** FAN ADVANCED resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacce use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of eause of death? 24a. Was an autopsy performed 1 Yes 1 ☐ Yes 2 ☐ No 2 0 N Division of Vital Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2/11/0 1 1 patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined lospitai or A 4 Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certific NENTHWEST HESPITAL CO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. CONANAN ORIANSO 31. Date filed (Month, Day, Year) #32. Registrar's Signature State SEP 1 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** September 8, 2004 11:45A Marie Frances Trapani /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 □ M 2 € F Director 216-12-5658 80 4/10/1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28e-1 show other traumatic event, the Medical Examinating the multified at MD Columbia 1 ☐ Yes 2 ☐ No Howard Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 5646 Waterloo Road 21045 U.S.a. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Tes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 2 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 12 should be filed with and Mental Hygien 7 is marked other th Secretary College 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Joseph Wisbeck Frances Kenecki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
importent: if item 27 is
any injury or other trau 5646 Waterloo Road Columbia, Maryland 21045 Diane Jaworiwsky/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 9/11/04 Dulaney Valley Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease stromplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Est only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Pinal disease or condition resulting in death) Pnysician weeles NOLLE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, the attending physician Physiclan/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year TARPANI & KHARIC FRANCES in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 □ Uпклоу signed by Part II. Other sig-ificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? res 2/10/No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 27. Manner of Death 1 (2) Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 0 To the Hospitei within 24 hours a To the Funerei Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. ignature and title of certifier completed caus of seath (Item 23a) (Type, Print) 6601 N. Charles Street hable 6 Towson, Md. 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State It Sports Registrar

**ORIGINAL** 

December Super Pick Modes Law   Land Teal A   VanPELT   Land Teal A   VanPELT   Land Teal A   VanPELT   Land Teal A   VanPELT   Land Teal A   VanPELT   Land Teal A   VanPELT   Land Teal A   VanPELT   Land Teal A   Land Teal			1- State of Maryland / Department of Health and Certificate of Death	d Mental H	ygiene	01 00017
LEATHER B. VANPELT  Examiner  A Explaination of the content of process and contents of the content of the conte					eath -	
## As Part Name of Construction of Descriptions and Part Name of Construction			LEATHA H. VANPELT			
PRIVACION DE LE CONTRACTA DE L	1		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De			
Some descript furnish protection of the protecti			MEMORIAL HOSPITAL CUMBERLAND		ALLE	GANY
Description   Description   Total Descriptio	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hours Number	Hrs. 8. Date of B	idb	9. Birthplace (State or Foreig
The control of the co	Director		213-24-5450 1UM 2KMF 87 Yrs. World Says 15613	Jan. 1	8,1917	
Continued and the control of the con	Pu .					10d Incide City Limit
Continued and the control of the con	sho	5				
Continued and the control of the con	the N	ecte			10a Citizon of	
Continued and the control of the con	with t	Ö				
Continued for the control of the con	s 23	era		(Specify Voe or h		
Clinton E. Smith    Sal pidematic NameRelations (Type Print)   19th Mailing Address (Sirnes and Mumber or Plusia Review Number, City or Town, State, 25 Code)   19200 VanPelt Drive, S.W. Rawlings, MD 21557   20th Mailing Address (Sirnes and Mumber or Plusia Review Number, City or Town, State, 25 Code)   12	ter d	Į,	Armed Forces?  1 Never Married 2 Married 1 Tyes 2 20 No	uerto Rican, etc.)	Bi	
Continued for the control of the con	36 irs af	by	If Yes, Give 1 ☐ Yes 2 ☒ No Specify:		Spec	ity: White
Continued for the control of the con	2 hou				16b. Kind of	
Continued and the control of the con	7. die 4. die 7.	pie	life_DO NOT use retired)	working		
Continued and the control of the con	d with	E O				Own Home
Continued and the control of the con	othe other		17. Father's Name (First, Middle, Last)  18. Mother's	Name (First, Midd	le, Maiden Surna	ime)
Company   Comp	rlar uld bu denta rked rked		Clinton E. Smith Magg	ie Crite	s	
Taburial 2   Cemation   Silber   Specify   Dawson   MD	ary shou	1	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or	Rural Route Num	ber, City or Town	n, State, Zip Code)
Taburial 2   Cemation   Silber   Specify   Dawson   MD	Mand 2		Frederick VanPelt/ Son 19200 VanPelt Drive	, S.W.	Rawlings	s, MD 21557
Dawson Cemetery 2004 Dawson, MD  22. Name and Address of Pacility  23. Sprain End of Surgest Location  24. Sprain Surgest Location  25. Sprain End of Surgest Location  25. Sprain End of Surgest Location  26. Sprain Surgest Location  27. Sprain Surgest Keyser, W 267.26  28. Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  26. Sprain End of Surgest Location  27. Sprain End of Surgest Location  28. Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  28. Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  28. Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  29. Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  29. Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  29. Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  29. Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  29. Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  29. Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  29. Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  29. Part I. Enter the disease, or completation of cause of death.  29. Part I. Enter the disease, or completation of cause of death	of He item	-	comptent examples of other place)		20c. Location	- City or Town, State
23a Part. Effect red classes, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	Page Page nent contribution	1	1 Zaburiai 2 Cremation 3 Chemoval from State		Dawso	on, MD
23a Part. Effect red classes, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	mit. partn porte vinju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Smith Fu	neral Ho	)me
Physician (Medical Examiner)  The proposal of the proposal of						
Physician   Medical Examiner   Medical Medic	- a		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care	diac or respiratory	arrest,	Approximate
Modical Examinor    Security   Se	Physician		Immediate Cause (Final			Onset and Death
Sequentially list conditions are consequence of):    Sequentially list conditions are consequence of):   Sequentially list						10 DAYS
The part of the pa	Examiner		BRONCHIECTASIS WITH EXACERBATION			
Due to (or as a consequence of):    Section   Due to program   Consequence of   Consequence		je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
Due to (or as a consequence of):    Section   Due to program   Consequence of   Consequence	cuted od ransi	mi	Cause (Disease or injury that initiated events c			
FEMALE   23d. Date of delivery   23d. Date of delive	O, exe an ar rrial-t	EX	resulting in death) Last  Due to (or as a consequence of):			
FEMALE   23d. Date of delivery   23d. Date of delive	176 Ite be Iysici	cal				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   Yes   2   No   3   Probably   4   Unknown	68 tiffica og ph as tf	Med	TETAL E			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   Yes   2   No   3   Probably   4   Unknown	OX th cer endir	N/UE	23b. Was decedent pregnant 23c. If yes, outcome or pregnancy 25c. If yes, outcome or yes,			,
The state of the s	deal deal	SICIS	1 Yes 2 10 4 Pregnant at time of death 5 Other (specify)		N	Ionth Day Year
The state of the s	at the by the stach	hys	3 🗆 Unknown			
25. Was case referred to medical saminer?  26. Place of Death (Check only one)  27. Mann of East  1   Yes	S, L		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Dio	1/	
25. Was case referred to medical saminer?  26. Place of Death (Check only one)  27. Mann of East  1   Yes	ord en si buld			_ 1	Yes 21XNo	3 Probably 4 Unknown
25. Was case referred to medical saminer?  26. Place of Death (Check only one)  27. Mann of East  1   Yes	as be	ple				. Were autopsy findings available
25. Was case referred to medical saminer?  26. Place of Death (Check only one)  27. Mann of East  1   Yes	The The ste ha	E O		_ per	formed?	death?
The part of the pa	ital	a				
Description of the part of the property of the part of	f V  ysic  is ce	.0	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursin	ig Home 5 ☐ Re	sidence 6 🗆 O	ther (Specify)
Description of the part of the property of the part of	of Pt in the three three in the real		27. Mann of Seath 28a. Date of Injury 28b. Time of 28c. Injury at			
Description of the part of the property of the part of	ndir ath. rr: Af	atic	Acident Investigation M 1 Yes 2 No			
D35481 SEPTEMBER 1, 2004  30. Name and address of person who completed use of eath (Item 23a) (Type, Print)  DR. MARK SAGIN, MEMORIAL HOSPITAL, SUITE 400, CUMBERLAND, MD 21502  State 31. Date filed (Month, Day, Year)  32. Begistrar's Signature	ViS rer de recto	life:	determined 289. Place of Injury - At nome, family, street, factory, office	28f. Location City or T	(Street and Num	nber or Rural Route Number,
D35481 SEPTEMBER 1, 2004  30. Name and address of person who completed use of eath (Item 23a) (Type, Print)  DR. MARK SAGIN, MEMORIAL HOSPITAL, SUITE 400, CUMBERLAND, MD 21502  State 31. Date filed (Month, Day, Year)  32. Begistrar's Signature	Dite on ris aft el Dii	Cer				
D35481 SEPTEMBER 1, 2004  30. Name and address of person who completed use of eath (Item 23a) (Type, Print)  DR. MARK SAGIN, MEMORIAL HOSPITAL, SUITE 400, CUMBERLAND, MD 21502  State 31. Date filed (Month, Day, Year)  32. Begistrar's Signature	ospi hou uner iy fill		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl	ace, and due to th	e cause(s) and n	nanner as stated.
D35481 SEPTEMBER 1, 2004  30. Name and address of person who completed use of eath (Item 23a) (Type, Print)  DR. MARK SAGIN, MEMORIAL HOSPITAL, SUITE 400, CUMBERLAND, MD 21502  State 31. Date filed (Month, Day, Year)  32. Begistrar's Signature	he H in 24 he F plete	edi	one) and manner stated.	coursed at the time		
30. Name and address of person who completed use of peath (Item 23a) (Type, Print)  DR. MARK SAGIN, MEMORIAL HOSPITAL, SUITE 400, CUMBERLAND, MD 21502  State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	To t To t	Σ	29b. Signature and title of certifier 29c. License number		29d. Date sign	ed (Month, Day, Year)
30. Name and address of person who complet use of eath (Item 23a) (Type, Print)  DR, MARK SAGIN, MEMORIAL HOSPITAL, SUITE 400, CUMBERLAND, MD 21502  State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	\		D35481		SEPTEMB	ER 1, 2004
State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	\0		30. Name and address of person who complet souse of yearh (Item 23a) (Type, Print)			
State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	٩		DR. MARK SAGIN, MEMORIAL HOSPITAL, SUITE 400, CUMBER	LAND, MD	215	02
			31. Date filed (Month, Day, Year) 32. Begistrar's Signature	-		

		4	For State Registrar	State of Marylar		artment of Hertificate of E			iene	nI.	2881.8	
			Decedent's Name (First, Middle, Last	)				2. Date of Deat		Yeer	3. Time of Death	٦
	Physicia /Medic		Lawrence		Wi	nkler		Seplen	rber	042		17
}	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat	h /		nty of Death	more	
			5. Social Security Number 6. Se	VIV. Stry HE x 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birth	place (State or Foreign	
	Funeral Director			M 2□F 96	Yrs.	Months Days	Hours Min.	(Month, Day, March 11	1908		imore,Marylan	d
	D ×		Usual Residence of Decedent  10a, State 10b, County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits	-
	Aaryla f sho	៦			imore Co						1 ☐ Yes 2 ☐ No	
	r 28e-	Director	Maryland Baltimore  10e. Street and Number	Lan	mible a	10f. Zip Code		1	0g. Citizen o	of What Cou	intry?	
	death with the Maryland oms 23e or 28e-f show ir neat be notified at	a D	1000 Franklin Avenue			21221			USA			_
	er dea	by Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No	I.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		lace - Amer lack, White		
336	urs aft	byF	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	if Yes, Give Year or Dates: WW		1 ☐ Yes 2 🔀 No	Specify:		Spec	<sup>city:</sup> Whi	.te	
21215-0036	72 hours after 'naturel', or ite	Completed	15, Decedent's Ed	ucation de completed)	16a. Dece	dent's Usual Occupa kind of work done d DO NOT use retired	ition furing most of wo	rking	16b. Kind of	Business/li	ndustry	
12	within ene. than	mpje	Elementary/Secondary (0-12)	College (1-4or 5+)	_		)		Llomo Tr	10C020E 70T	ent Industry	i
	filed v Hygie other t	ပ္	12 17. Father's Name (First, Middle, Last)	N/A	Plaste	rer	18. Mother's Na	me (First, Middle, I		-	HIC HOUSTLY	
lan	fental rked c	To Be	Valentine Winkler				Margaret	Carnes				
Maryland	and M le mar		19a. Informant's Name/Relationship (7	ype, Print)		ng Address (Street a					ip Code)	
dî.	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene item 23 is marked other than "naturel", or items 23e or 28e-1 show other treumatic event, the Madical Exaction must be notified at		Doris Peterson  20a. Method of Disposition	20h		Glarin Way			yland 2 20c. Locatio		own. State	-
Por	ages nt of h h: # ite		1 ☐ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify			osition (Name of matory or other place emetery Sept			Baltimon	1		
Baltimore,	permit. Pages 1 Department of F Important: If ite any injury or ot		21. Signafure of Funeral Service Licen			2. Name and Addres	s of Facility					1
ä	Depa Impo any ii		Matha dassalv	Characki		Lassahn Fut 7401 Belain	ecal Hon- r Road Bal	Inc timore,Mary	land 2	1236		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not en	ter the mode of dying	g, such as cardia	c or respiratory arr	est,		Approximate Interval Between Onset and Death	
V.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Kespira		fort	ure				SIX MENT	12
ı	Examiner			Due to (or as a conse	Livo	Heavy	+ Di	sease			one Year	r
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):	775.01	1072				1	
	ecuter and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	quence of):							_
760,	ate be executed hysician and he burial-transit	cai E		d	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
68	tificate g phy: as the	e							e e			
Вох	death certifica e attending ph ed for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr	al death 3[	⊒Ectopic pregnancy				Date of deliment	very Day Year	
ю. В	t the dea by the at lached fo	ysici	1  Yes 2 No	4□Pregnant at time of 9□Unknown	death 5[	Other (specify)		· · · · · · · · · · · · · · · · · · ·			=====	
Δ.	tha de		Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	underlying cause give	en in Part I.	23e. Did to	bacco use c	ontribute to	the cause of death?	
rds,	quires en sign	ed by	Chronic 1	tenul in	Suffi	Geny		1 🗆 Y	es 2 🗆 No	3 🗆 Pro	obably 4 Unknown	_
Record	e law requ has been je 2 shoul	Completed	Chronic	Anemia				24a. Was a autop: perfor	in 24	b. Were au prior to d death?	topsy findings available ompletion of cause of	
E R		Con	Deripheru	( Vasa	elan	- dise	usl.	1 ☐ Yes	2 □ No	1 Yes	2 □ No	_
Vital	Physician: Th rthis certificate ral director, pag	o Be	25.Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatient 2[	 ☐ ER/Outpatie	nt 3□ DOA Othe	ar d	ath (Check only or Home 5 - Resid		Other (Spec	eifv)	
1 0	g Physer this	<b> -</b>	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe h			,,	
sior	Attending In death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	1			Yes 2 □ No	00/ 1	A		ral Route Number,	
Division	- 0 -	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	nome, tarm, si cify)	treet, factory, office		City or Tow		iniber or Au	rai noule ivuniber,	
	spitel		29a. Certifier Certifying Ph	ysicien: To the best of my kr	nowledge, dea	th occurred at the tin	ne, date and place	e, and due to the o	ause(s) and	manner as	stated.	-
	To the Hospitel or within 24 hours aff To the Funerel Discompletely filled in	Medical	(Check only 2 Medicel Exer	niner: On the basis of examir and manner stated.	nation and/or in							
	To T	Σ	29b. Signature and title of certifier	Guo, M	D	29c. Licens	e number		Date sig	gned (Month	n, Day, Year)	11
	NI		30. Name and address of person who	9 / 111/	om 23a) (Tvne	Print)	10-10-	, ,	egsre	1000	200	7
	371		5601 Loch R	aven Bou	levare	l Bal	timore	e, MD	2/23	9 0	linglin Gu	0
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	N. D				/		
	Regist	rar	SEP 1 0 2004	Jean D	1	195						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylan		artment of tificate of			Reg. No	2001	28849
	Physici /Medio		Decedent's Name (First, Middle, Last)     EVELYN WHEATLEY					2. Date of De Month SEPTEM	BER Da	8, 2004	3. Time of Death 5:15 A.M
	Examin Funeral Director		4a. Fecility Name (If not institution, give s  HOLY CROSS NURSING  5. Social Security Number  577-24-9546		last birthday) Yrs.	4b. City, Town, BURTONS If Under 1 Yea Months Days	r If Under 24 Hr	s. 8. Date of Bir	th ay, Year)	ONTGOME  9. Bird	
φ			Usuel Residence of Decedent  10a. State 10b. County		y, Town or Lo	cation		Madasi		700	10d. Inside City Limits
	8a-f eh	ector	MD PRINCE GE	EORGES	LAUREL	1					1 (X) Yes 2 □ No
	h with the	ai Dir	10e. Street and Number 9250-4 CHERRY LAN	ΙE		10f. Zip Code 20708			_	tizen of What Co U.S.A.	ountry ?
20	in 72 hours after death with the Marylan "naturel", or teme 23a or 28s-1 show social Examiner must be notified at	by Funeral Director	11. Marital Status 1  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates:			Hispanic Origin? ( ban, Mexican, Pue o <i>Specify:</i>	Specify Yes or No rto Rican, etc.)		14. Race - Ame Black, Whit	
0500-6171	within 72 hours after death with the Maryland ene. Then *paturel', or tleme 23a or 28a-f ehow he Madical Examiner must be notified at	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	lent's Usual Occi kind of work don DO NOT use retii ERK TYPI	e during most of wo red)	orking		ind of Business	,
N	filed Hygi Hygi ent,	Be Co	12TH 17. Father's Name (First, Middle, Last)					ame (First, Middle			NC/VI
2	D & 3 0	To	SAMUEL MULLIKIN  19a. Informant's Name/Relationship (Type	ne Printl	19b Mailin	o Address (Stree	UNAVA	I LABLE	er City o	or Town State	7in Code)
Ĕ	d 2 th a tra		ISABELLE JAHN/DAL	IGHTER	9250-	-4 CHERR		AUREL, MI	D 20	708	
nore	ages 1 ant of He it: If iten y or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, cren	sition (Name of natory or other pi	TORY 9-9-	Date		ocation - City or REL, MD	Town, State
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Sign ture Funeral Service License	е ,	22	. Name and Add	ress of FacilityFLI	ECK FUNEI	RAL	HOME, INC	2. 7
) [	Physician		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death e cause on each line. CONGESTIVE				ac or respiratory a	rrest,		Approximate Interval Between Onset and Death 4 YRS.
	/Medical Examiner	niner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	HYPERTENS  Due to (or as a consequence of the conse	IVE HEA	ART FAIL	URE				10 YRS.
8/pn, <	icate be executed; physicien and s the burial-transit	edical Examiner	that initiated events coresulting in death) Last	Due to (or as a consequ	uence of):						
BOX C	ath certif attending for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of di	death 3	Ectopic pregnan Other (specify)	су			23d. Date of del Month	ivery Day Year
cords, P	law requires that the de as been signed by the 2 should be detached	by	Part II. Other significant conditions con HYPOTHYRODI	-	ulting in the ur	nderlying cause g	liven in Part I.				the cause of death?
	The lay ate has page 2	Completed						24a. Was autoj perfo 1 🗆 Yes	psy ormed?	prior to death?	topsy findings available completion of cause of 2 No
VITAI	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 X No	ospital: 1 tnpatient 2	ER/Outpatien	1 3 DOA	thon	eath (Check only of Home 5 Resi		6 ∏Other (Spe	cifv)
_	<b>5</b> 0 0	tion: T	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj		28d. Describe			,
DIVISION	To the Hospitel or Attandin within 24 hours after death.  To the Funerel Director: At completely filled in by the fun	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, office	Э	28f. Location ( City or To	Street an wn, State	nd Number or Ru	ral Route Number,
	Hospit 24 hours Funere etely fille	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the restigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as d place, and due	stated. to the cause(s)
	To the To the complex	Me	29b. Signature and title of certifier	1.0			nse number		29d. Da	te signed (Monti	n, Day, Year)
•	/		30. Name and address of person who con	mpleted cause of death (Item	1 23a) (Type,	Print)	755		SEPT	TEMBER 8	2004
	5		CHRISTINE DELIMA,	M.D. 7350	VAN I		#260 LA	AUREL, MI	207	707	
4	Sta	ite	31. Date filed (Month, Day, Year) SFP 1 0	32. Registrar's Signa	inia	4 1					

1	725		State of Maryland / De 1 - State Ragistrar Unpend Item #23a&27 per me G	partment of Health and Mealth and Mealth	lental Hygi	ene . ne. 004 28850		
	D1		Decedent's Name (First, Middle, Last)		2. Date of Death Month	_ 3. Time of Death		
	Physici /Medio		Geoffrey Ray Ward		Septembe	er 04, 2004 1410 P M		
	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
			Laurel Regional Hospital	Laurel		Prince George's		
$\mathcal{S}_{\mathbf{J}}$	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 114-54-0645 55 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,	o of Birth hth, Day, Year)  9. Birthplace (State or Foreign Country)		
7	Director		Usual Residence of Decedent		05/08/19	949 Indiana		
	yland ow		10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits		
	ath with the Marylan 23a or 28a-1 show	to	MD Prince George Laurel			1 ☐ Yes 2 📉 No		
	h the	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?		
	th wit	a D	12215 Shade Tree Lane	20708		U.S.A.		
	eme erme	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.		
36	ours after o et', or Iter Examiner	by Fu	1 ☐ Never Married 21☐ Married 12☐ Yes 2 ☐ No	1 ☐ Yes 2 No Specify:	mount, ord.)	Specify: White		
Ö	72 hours after death with the Maryland "neturel", or iteme 23a or 28a-f show odical Examiner must be notified at		3 Widowed 4 Divorced Year or Dates:	adamb librat On the National Control of the National C				
5	c = 38	Completed	(Specify only highest grade completed) (Gin	edent's Usual Occupation e <i>kind of work done d</i> uring most of worki DO NOT use retired)	ing 10	6b. Kind of Business/Industry Smithsonian Museum of		
212	with iene.	E O	Elementary/Secondary (0-12) College (1-40r 5+)	inet Maker	1	American History		
b	e filled I Hyg othe	· o	17. Father's Name (First, Middle, Last)	18. Mother's Name				
/lar	uld bu Menta Irked Itic e	To B	Harold Ward	Betty D	ickson			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "any injury or other treumetic event, Ina Magnes.			ling Address (Street and Number or Rura				
	l and fealth m 27 her tr			5 Shade Tree Lane,				
õ	it of the state of		I burial 2 Cremation 3 Linemoval from State	ematory`or other place)	0	Oc. Location - City or Town, State		
Baltimore,	it. Partmer			ill Mem. Garden 22. Name and Address of Facility F1		Osceola, Indiana		
Ba	Depa Impo any i		AND AND	. 1.1		eral Home, Inc. irel, Maryland 20707		
			23a. Part1. Enter the disease, or complications that caused the death. Do not e			t. Approximate		
. II	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final  Atherosclerotic	Cardiovascular Dis	10000	Interval Between Onset and Death		
	/Medical		disease or condition resulting in death)  ALIPETOSCLETOLIC  Due to (or as a consequence of):	Carciovascular DIS	sease			
	Examiner		Sequentially list conditions					
	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Unter Underlying Cause (Disease or injury					
	and I-tran	Examiner	that initiated events resulting in death) Last c.  Due to (or as a consequence of):					
8760,	certificate be executed Iding physician and Ise as the burial-transit							
687	ificate g phys	edic	d.			,		
Box	anding use a	Z	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery		
	death	sicia	1 Ves 2 No. 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (s <i>pecify</i> )		Month Day Year		
P.0	w requires that the death certific been signed by the attending p should be detached for use as	Completed by Physician/Medical	9 ☐ Unknown 9☐ Unknown		<u> </u>			
	igned be de	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?		
Vital Records,	requi	eted			1 Yes	2 No 3 Probably Dhknown		
Sec	e la has je 2	nple.			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
alF	icien: The certificate ha rector, page				1 Yes 2	od? death? No 1 Yes 2 No		
Σ	Physicien: this certific al director,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death				
of		1: 10	1 XYes 2 No No No Note 1 Inpatient 2X ER/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time	ont 3 DOA 4 Nursing Hor	ne 5 🗌 Resident 28d. Describe how	ce 6 Other (Specify)		
0	Attending r death. ector: After by the fune	tio	1 XNatural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	of 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No		anjury oscuriod		
Division	Attendir death.	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	treet, factory, office		et and Number or Rural Route Number,		
	tel or s afte el Dir ed in	Certification;	4 Homicide Getermined building, etc. (Specify)		City or Town, S	State)		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)  1 ☐ Cartifying Physician: To the best of my knowledge, dea 2 ☐ Medical Exeminer: On the basis of examination and/or and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)		
	To t To t	Σ	29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Month, Day, Year)		
			Manfanta helfall and	O.C.M.E.	Se	eptember 05, 2004		
			30. Name and address of person who completed cause of death (Item 23a) (Type					
		20		11 Penn Street, Ba	ltimore,	Maryland 21201		
	Sta			5 Sparks				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day September 8,2004 Frank Wilson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Agnes Baltimore Healthcare If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1⊠M 2□F Hours 77 217-20-6059 Yrs. Feb 9, 1927 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland Catonsville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2022 Edmondson Avenue 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 XNo Specify: White Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Defense Contractor 12 Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Wilson, Sr. Grace E. Boteler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene M. Wilson / Wife 2022 Edmondson Avenue, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/9/2004 Bayview Crematory <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HSCVD disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Year 4☐Pregnant at time of death Month Dav 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked oth any Injury or other traumatic event, sonce.

**Physician** 

/Medical

Examiner

10a. State

Director

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Completed

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**Funeral** 

Director

7 is marked other than "natural", or iteme 23e or 28a-f ehow traumatic event, the Medical Examinar must be notified at

e filed within 72 hours after de I Hygiene. Il Hygiene. other then "natural", or item

Baltimore, Maryland 21215-0036

Physiclan/Medical þ Be Completed 25. Was case referred to medical

Dheumonia

5 Pending

investigation

6 Could not be determined

examiner

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

Medical

4 T Homicide

(Check only one)

29b. Signature and title of certifie

1 Yes 2 □ No

Examiner attending physician and for use as the burial-transit has 70 After

Certification: death.

after death Director: 24 hours a the

Registrar

1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown

autopsy performed 2 No

Baltimore, MD

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D0053312 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

Henggeler, mo 900 caton avenue 32. Registrat's Signature 10

	•	For State Registrar	State of Maryland	•	ment of He			iene	28852
		Decedent's Name (First, Middle, Last)					2. Date of Deal	th Day Year	3. Time of Death
Physicia /Medic		Curtis Edwir		Willi	s Jr.			ber 6, 200	4 7:40 A M
Examin		4a. Facility Name (If not institution, give str		4b	. City, Town, or	Location of Death		4c. County of De	ath
		305 Shipley Avenue			Glen B				ne Arundel
Funeral		5. Sociel Security Number 6. Sex	7. Age (In yrs. la	Mo	Under 1 Year onths Days	Hours Min.	8. Date of Birth (Month, Day	Year) 9. Bi	rthplece (State or Foreign Country)
Director		219-01-2402	83	Yrs.			2-28-19	021 MD	
and w		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location	on				10d. Inside City Limits
Aaryla Sho	5	MD Anne Aruno	Io1 Clar	n Burnie					1 □Yes 2 ₩ No
with the Marylan a or 28a-1 show be notified at	ect	10e. Street and Number	iei Giei		Of, Zip Code		1	log. Citizen of What C	Country?
th with 23a or	₫	10.000			21061			USA	
(G 35	Funeral Director	305 Shipley Avenue	. Was Decedent Ever in U.S	i. 13. Was	Decedent of His	spanic Origin? (S	pecify Yes or No-	14. Race - Am	
s after dea	교	1 ☐ Never Married 2X Married	Armed Forces? 194	1-		n, Mexican, Puert	o Hican, etc.)	Black, Wh	
rel', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 194	6	Yes 2 No	Specify:		Specify:	White
72 hours natural	Completed	15. Decedent's Educa (Specify only highest grade	ition completed)	(Give kind	s Usual Occupa of work done d	luring most of wor	king	16b. Kind of Busines	s/Industry
thin thin	npldu	Elementary/Secondary (0-12)	College (1-4or 5+)		VOT use retired,			Ctata of 1	Maruland
be filed within 72 hr. ntal Hygiene. od other than "natu svant, the Madical	ပ္ပ	12		Hearin	ng Offic		no (First Middle	State of I	Maryland
be fill	Be	17. Father's Name (First, Middle, Last)	- C			Anna \		walden daniane)	
12 should be filed within h and Mental Hygiene. 7 is marked other than "Irsumetic sysnt, Ina Men	2	Curtis Edwin Willis		10h Mailing A	ddraes (Straat a			r, City or Town, State,	Zip Code)
d 2 s th an 7 is r trsur		Elizabeth Willis /	_					ie, Maryla	
1 an Heal Heal Sm 2	-	20a. Method of Disposition	20b. Pla	ace of Dispositio	n (Name of	1		20c. Location - City	
ages intof t: Hill		1 Burial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)	moval from State 1	metery, cremato yland Ve		_	.0-2004	Crownsvill	e, Maryland
nit. P artme ortan injur.		21. Signature of Funeral Service Licenses			ame and Addres		nalatan	Funeral H	omo P A
permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked sny injury or other trsumatic sydnes.		> Mark A. Van	une Mo13.	57 1 5	Second A			ie, Md 210	
2316		23a. Part1. En The disease, or complic	ations that caused the death.						Approximate Interval Between
Physician	'n	shock, or heart failure. List only one Immediate Cause (Final	Cip -	0	Och	120			Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequ	ence of):	DEO	1114			
Examiner		h h		0	Je m	enti	2		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):					
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s be exe sician a buriat-	EX	resulting in death) Last	Due to (or as a consequ	ence of):					
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entific ling p	Med	IF FEMALE:	c. If yes, outcome of pregnar	2011				201 0-1	elt
attence attence for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 □Ect	opic pregnancy her <i>(specify)</i>			23d. Date of d Month	Day Year
the de	Physician/M	1 Yes 2 No	9 Unknown	30	ilei (specity)				
vequires that the death certificate been signed by the attending of should be detached for use as the		Part II. Other significant conditions cont	ributing to death but not resu	Iting in the under	rlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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w requir been si should	Completed						24a. Was a	an 24b. Were	autopsy findings available
he law s has l	Ĕ			·			autop	med? death'	
VICIAN: The ician: The certificate rector, pag	C	25. Was case referred to medical				26 Place of De	1 ☐ Yes ath (Check only or	2 No 1 Ye	as 2LNo
Physician: Physician: rthis certifica	0 8	avaminar?	ospital: 1 ☐ Inpatient 2 ☐ 8	ER/Outpatient :	3□ DOA Othe			lence 6 Other (Sp	pecify)
ding Phys	on: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun		, , , , , , , , , , , , , , , , , , , ,	ow injury occurred	
SION tanding feath. tor: Afte the fune	atlo	2 ☐ Accident 5 ☐ Pending investigation	(Month, Day rear)			Yes 2 □ No			
VIS Afte er de recto by th	tifle	3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, street,	fectory, office		28f. Location (S City or Tow	itreet and Number or i m. State)	Rural Route Number,
rs after on ed in	Certificati								
To the Hospital or Attanding Physician: The within 24 hours after death. To the Funaral Director: After this certificate h completely filled in by the funeral director, page	edical	29a. Certifier Certifying Phys	ician: To the best of my know er: On the basis of examinat	wledge, death oc	curred at the tim	ne, date and place pinion, death occi	a, and due to the durred at the time.	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
the F hin 24 the F		one)	and manner stated.		29c. License			29d. Date signed (Mo	
or with	Σ	29b. Signature and title of certifier	200	//_	230. Liberisi	アノイー	-)		7 2020
		0/10/	Cie		1 1	, ) ,	/	DYHEADE	1,007
1		30 Name and address of person who	noteted cause of death (Item	23a) (Type, Prir	176/1	7 inp	6. R.	mm Pel-	2106/
	10	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture		11/0	THE WOL	7-1/-7	
Sta Regist		SFP 1 0 2		K A	and a				

with the Maryland

death v

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician** 2004 August 31, 0200 A M Justin Roland Winder /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Pay, Year) 8/11/1983 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Maryland 1X M 2□ F 21 215-04-1121 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28e-f show treumatic event, the Medical Examinations to notified at 1X Yes 2 □ No N/A Baltimore Director MD 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 1118 Dundalk Avenue permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ in eny injury or other treumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩNo If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 21X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Patricia Foskey Ronald Winder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1118 Dundalk Avenue Baltimore, Maryland 21224 Patricia Foskey/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 9/4/04 Baltimore, Maryland Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 21. Signature of Funeral Service Licenses 6415 Belair Road Baltimore, Maryland 21206 Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complete shock, or heart failure. List only one one cause on each line Immediate Cause (First disease or condition resulting in death) Priysician /Medical Due to (or all a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) signed by the at be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ▶ Yes 2 □ No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Other: 4 Nursing Home Hospital: 5 ☐ Residence 6 ☐ Other (Specify) 1 Npatient 10 1X Yes 2 □ No 2 ER/Outpatient 3 DOA 28a. Date of Injury 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 27. Manner of Death Certification; Year 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 12/01/4 48/316x 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6100 Cording an el within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one)

The law requires that the death certificate be executed

Hospitel or Attending Physicien:

the

signed by

has certificate

After this

after death.

Division of Vital Records, P.O. Box 68760

State Registrar THEY WAFM, K 31. Date filed (Month, Day, Year)

SEP 1 0 2004

29b. Signature and

and manner stated.

30. Name and address of person who completed duse of death (Item 23a) (Type, Print)

2. Registrar's Signature

29c. License number O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d, Date signed (Month, Day, Year)

August 31, 2004

		1	State of Man		artment of Health and tificate of Death	Reg	ene . No. () () ()	28854
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Lucille 4a. Facility Name (If not institution, give street and number)		Youngblood  4b. City, Town, or Location of De	2. Date of Death Month 09	Day Year O3 2004 4c. County of Death	
	Funeral Director	CI	Joseph Richey Hospice  5. Social Security Number  1 M 2/2 F	In yrs. last birthday) 62 Yrs.	Baltimore If Under 1 Year   If Under 24 H Months   Days   Hours   M	8. Date of Birth (Month, Day, Y	9. Birth Cou	plece (State or Foreign intry) VA
	he Maryland 8a-f show cullied at	ector	MD NA I	Oc. City, Town or Loc	e	100	J. Citizen of What Cou	10d. Inside City Limits 1
9-0036	within 72 hours after death with the Maryland ene. Than "neturel", or items 23a or 28a-f show Ta Masilcal Exstrict most be notified at	ted by Funeral Director	10e. Street and Number  4139 Norfolk Ave  11. Marital Status  1 Never Married And Married 3 Widowed 4 Divorced  15. Decedent's Education	16a Deced	10f. Zip Code  21216  Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Put I — Yes 2X No Specify:	(Specify Yes or No- erto Rican, etc.)	U.S.A.  14. Race - Ameri Black, White	ican Indian, , etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netur any injury or other treumatic event, It e Musical Once.	To Be Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12th grade NA  17. Father's Name (First, Middle, Last)  Cleveland Hargrove  19a. Informant's Name/Relationship (Type, Print)	Но		Name (First, Middle, Ma	ve	
3/64 Baltimore. M	permit. Pages 1 and 2 Department of Health & Important: If item 27 I any injury or other tre		21. Signatule of Funeral Service Licensee	King Mem	norial Park 9.  Nome and Address of Facility  Arch F/H West	/11/04 Ra	andallsto	
NA ON	Physician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as death. Do not enter ASTRIC consequence of):	er the mode of dying, such as care	dia or respiratory arrest	t,	Approximate Interval Between Onset and Death Zyr9
0. Box 68760.	death certificate e attending phys ed for use as the	Physiclan/Medical Example Example 2015	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 24 No 9 Unknown	☐ Fetal death 3 ☐	□Ectopic pregnancy □ Other (specify)		23d. Date of delin Month	very Day Year
ngbloo	e law requires has been sign	Completed by Ph	Part II. Other significant conditions contributing to death but Dementia	not resulting in the ur	nderlying cause given in Part I.	1 ☐ Yes  24a. Was an autopsy performe	prior to c	obably 4 Unknown topsy findings available ompletion of cause of
i/le 400	ding Physicien: h. After this certific funeral director,	Certification: To Be C	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day ) (Month, Day ) 28b. Place of Injury (Month, Day ) 28b. Place of Injury building, etc.	28b. Time of Injury	Other: 4 Nursing 1 Nursing 1 Nursing 28c. Injury at Work?  M 1 Yes 2 No	Death (Check only one)  19 Home 5 Residence 28d. Describe how  28f. Location (Streen City or Town,	ce 6 Other (Spec rinjury occurred	
Tuc	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	Medical Ce	29a. Certifier  (Check only one)  Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state  29b. Signature and title of certifier	xamination and/or in	h occurred at the time, date and pivestigation, in my opinion, death of	occurred at the time, date	ise(s) and manner as e and place, and due	to the cause(s)
	4		30. Name and address of person who completed cause of dea	ith (Item 23a) (Type,	D24170 NEWTOWST	Baltimo	September	4,2004
	St Regist	ate rar	31. Date filed (Month, Day, Xear) SEP 1 0 2004  32 Aegistrar	s Signature	rester	200 111		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician ZANDICK DAVID September 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore Hospita Sinan 04 It Under 1 Year If Under 24 Hrs. 8. Date of Birth AUG. 31, 1926 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days 1 M 2 □ F 78 Yrs 212-22-9325 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10h County 10a State item 27 is marked other than "netural", or items 23e or 28a-f show other traumatic event. Its Madical Examinar must be notified at BALTIMORE Director N/A 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21215 USA 2500 WEST BELVEDERE AVENUE by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 2 should be filed within 72 hours after c and Mental Hygiene. Is marked other than "netural; or iten 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 ¥ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) zandick, David Elementary/Secondary (0-12) College (1-4or 5+) SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ELIZABETH ZANDICK Η. ABRAHAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8 POMONA WEST #9 - BALTIMORE, MD 21208 t of Health if item 27 i STANLEY ZANDICK / BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State MD VETERANS CEMETERY 9/9/2004 OWINGS MILLS, MD Department of Important: if any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pinysician Aspiration phedmonia disease or condition resulting in death) /Medical Due to for as a consequence of Examiner cancer Metastatic Se uentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours after To the Funeral Di

ed by the a detached f

certificate has b irector, page 2 sl

this After thi funeral

Director:

þ

Completed

Be

P

Certification:

ical

2 Accident

3 🗍 Suicide

4 Thomicide

in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown

2 □Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

o mono cutic

25. Was case referred to medical examiner? Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 5 Pending investigation 1 Natural

28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

28c. Injury at Work? 1 🗌 Yes 2 No

3□ DOA

3 Ectopic pregnancy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 🕱 No

24a. Was an

1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death Check on one

autopsy performed? 2 X No Month

23e. Did tobacco use contribute to the cause of death?

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year,

29b. Signature and title of certifier

6 Could not be determined

19021

September

OOCE

3. Time of Death

N/A

Birthplace (State or Foreign Country)

WHITE

RETAIL

Approximate Interval Between Onset and Death

48 hours

ears

Year

**JACOBSON** 

10d. Inside City Limits

1 Yes 2 □ No

3:30AM

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of

MD

MD. Sinai Hospital Huana

31. Date tod (Month, Day, Year) SEP 1 0 2004 32. Registrar's Signature

DHMH 17 Rev 1/200

4

State Registrar

**ORIGINAL** 

Baltimore, 2401 W Belvedere Ave, Baltimore MD 212

CPM 04-05775 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. June Ellen Angel UNK 04-300 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** June Ellen Angel September 07, 2004 10:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 630 Sandy Hill Road Anne Arundel Severn If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 1 F Months 35 Yrs. Director 220 84 0312 July 8, Maryland Usual Residence of Decedent the Maryland 10a State 10h County 10d. Inside City Limits 10c. City, Town or Location arthan "natural", or Items 23a or 28a-f ehow The Medical Examinat must be notified at 1 ☐ Yes 2 X No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Bear Ridge Road Apt. 3 21222 U.S. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 Specify: White by 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be if Health and Mental item 27 Is marked o Margaret Carmella Augustowski David Wayne Etzler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Augustowski/Mother 210 Weat Edgevale Road Baltimore, Maryland 21225 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 o i 1 Burial 2 Cremation 3 Removal from State ö permit. Page Department of Important: If any injury or once. Bayview Crematory 9/9/2004 \* 4 ☐Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service License 4001 Ritchie Highway Baltimore, Maryland 21225 rances Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Blunt torce Injuries **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit be executed Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has death? 2 🗆 No Yes 2 🗆 No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6XXCther (Specify) SCLINE Hospital: 1∑ Yes 2 □ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury Found 9704 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Found subject assaulted 1 Natural 5 Pending 1 ☐ Yes 2 ☑ No investigation 10:49AM Hospital or Attendi 24 hours after death Funeral Director: A 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Foliad in worlds 281. Location (Street and Number or Rural Route Number, City or Town, State) Found at 630 Sandy Hill Rd, Anne Avundolophi 4 Homicide To the Hospital within 24 hours a To the Funeral E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month, Day, Year)

3 2004

29b. Signature and title of certifier

ma 32. Registrar's Signature

tallan wo

O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

September 08, 2004

111 Penn Street, Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

Miles D. Sparke

	Please	e Type or	Print i	n Blaci	k In	delible lnk.	. Ensur	re All C	copies /	Are Le	eaible		
						artment of H					· 5		
1 - For State Registrar						rtificate of			Re	g. No.	04	288	357
Decedent's Name (First)									Date of Death Month	Day	Year		me of Death
Anna Louise									ptembe				10 P M
4a. Facility Name (If not in:	-				-	4b. City, Town, o		Death			ounty of Dea		
Gilchrist Ho							wson			Ва	altimo	ore	
5. Social Security Number 277 24 3982		.Sex 1 ☐ M 2 [2] F	7. Age (In y	yrs. last birth Y	thday) Yrs.	If Under 1 Year Months Days			Date of Birth (Month, Day, Ct. 20, 1	924	9. Bir Wes	irthplace (Sta Country) TV1rc	tate or Foreign ginia
Usual Residence of Deced			100	Oit Tour								T	
Maryland 10b. 0	County		100.	c. City, Town B		timore							de City Limits Yes 2 ☐ No
10e. Street and Number						10f. Zip Code			10	n. Citizer	n of What C	`ountry?	
2820 Louise	Δveni	בוי				2121	1 /			-	JSA	Ouring.	
11. Marital Status	- I	12. Was Dece	adent Ever	in 11 G	13.1	Was Decedent of H		-2 /Chacify	Yan or Non			nerican India	-
1 Never Married 2	Married	Armed Fo	orces?	n 0.5.	I If	was Decedent of H If Yes, specify Cuba	an, Mexican, P	Puerto Ricar	n, etc.)	1 ***	Black, Whi	ite, etc.	a,
3 🔀 Widowed 4 🗆 Di	Divorced	If Yes, Giv Year or D	ive			1 ☐ Yes 2 ☑ No					Specify: White		
(Specify only		grade completed)		16a. I	Decedi (Give I life. [	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of d)	of working	1	6b. Kind	of Business	s/Industry	
Elementary/Secondary (		College (1	1-40r 5+;			Packer			C	onta	ontainer Mfg.		
17. Father's Name (First, A		•		_			18. Mother's	s Name (Firs	rst, Middle, Ma	aiden Sui	mame)		
Chester Atla	ıs Whi	ite							Russe				
19a. Informant's Name/Re Ernest Butte						ng Address (Street Louise Av						Zip Code)	
20a. Method of Disposition 1 ⊠Burial 2 □ Crem 1 □ Donation 5 □ O	mation 3		State	cemetery	y, crem	sition (Name of matory or other place of Faith		Date 14/200				or Town, State	
21. Signature of Funeral S			nko.		Br	Name and Address CUZDZINSK 407 Old E	ess of Facility	eral Ho	Iome P.	Α.			
23a Part1. Enter the dise.	ase, or con	mplications that c	caused the d	death. Do no	ot ente	ar the mode of dyir	ng, such as car	irdiac or res	piratory arre	st,	Mu -	Approxi	imate I Between
Immediate Cause (Final	O. 41.22					failure						Onset a	and Death
disease or condition resulting in death)	-		(or as a cons			791101						Year_	5
		1	(01 20 2	sonsaquanca oi).									
Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	ate 📕	b. — Due to	(or as a cons	sequence of	f):								
that initiated events resulting in death) Last		c Due to (	(or as a con:	consequence of):									
IF FEMALE:		d	· · · · · · · · · · · · · · · · · · ·										
23b. Was decedent pregnatin the past 12 months 1 □ Yes 2 ☑ No 9 □ Unknown		1☐Live b	binth 2.⊟F nantattimero	Fetal death		Ectopic pregnancy Other (specify)	:			23d.	Date of de Month	elivery Day	Year
Part II. Other significant c	conditions	contributing to d	eath but not	resulting in	the ur	nderlying cause giv	en in Part I.	- :	23e. Did toba	ecco use r	contribute f	in the cause	of death?
Atrial fibri												robably 4	
								-   -	24a. Was an autopsy performe	ed?	death?	λ.	ngs available of cause of
25. Was case referred to n	medical	1					ac Blace of			No	1 🗆 Yes	s 2 No	
examiner?	nouio	Hospital:	Inpatient 2	2 ER/Outp	patient	t 3 DOA Othe	26. Place of liner: 4 Nursin		eck onlv one) 5 □ Residen		Other (Spe	ecity) Hosi	Dize.
	Pending investigatio		of Injury oth, Day Year,	28b. Tir Inj	ime of njury	28c. Injury Work	y at	28d. D	Describe how				-

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certilicate be executed To the Funeral Director: Atter this centificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Funeral Director: A

IF FEMALE: 23b. Was deced Part II. Other sig 25. Was case re-27. Manner of De

3 Suicide

29a. Certifier (Check only one)

4 - Homicide

29b. Signature and title of certifier

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

Be

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: It item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** /Medical **Examiner** 

> Jason 31. Date filed (Month, Day, Year) State Registrar

mos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

00061199

29c. License number

Charles

57

tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) Sept 12 2004

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Touson MD 21204

Black

SEP 1 3 2004

6 Could not be determined

32. Registrar's Signature

i N. 5825	But.	ler	Please Type	e or Print in Black I	ndelible lnk	. Ensure All	Copies A	e Legible	e.
3623			1 For State	ate of Maryland / De			ental Hygie	ne	
			Registrar	C	ertificate of	Death	Reg.	No. U U 4	28858
	Physici	an	Decedent's Name (First, Middle, Last)      Trileler	Di	ıtler		2. Date of Death Month	Day Yea	
}	/Medic		Vikki 4a. Facility Name (If not institution, give street			or Location of Death	September	10, 20 4c. County of D	04 0140 A. M
	LXaIIIII	lei	Caton Manor Nursing H		Baltimon				/A
F	uneral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda		If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9.	Birthplace (State or Foreigr Country)
D	irector		216-88-5520 Usual Residence of Decedent	28 Yrs.		1.00.0	June 10,		Maryland
land	M til		10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
Man	a-f sh	ctor	Maryland Baltime	ore		Dundalk			1 ☐ Yes 2 🛣 No
ith the	or 28	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What	Country?
ath w	s 23a	rai	35 Eastship Road			21222		United	
ter de	item T	by Funeral	Ar	as Decedent Ever in U.S. med Forces?  ☐ Yes 2 [] No	<ol> <li>Was Decedent of I If Yes, specify Cub</li> </ol>	Hispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)		merican Indian, /hite, etc.
<b>036</b>	e!; o	by	If '	Yes, Give ear or Dates:	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
1215-0036 within 72 hours after death with the Maryland	natur	Completed	15. Decedent's Education (Specify only highest grade com	pleted) 16a. Dec	cedent's Usual Occup	pation	165	. Kind of Busine	ss/industry
Maryland 21215-0036 d 2 should be filed within 72 hours af	hen .	mpi		ollege (1-4or 5+)		during most of workird)	,g	/	
filed v	thar t	ပိ	10 Years 17. Father's Name (First, Middle, Last)		Disabled	18. Mother's Name	/First Middle Mai	N/A	
land be	cava	To Be	Leroy Orval Butler				ey Lynn C		
aryla should	mari	F	19a. Informant's Name/Relationship (Type, Pr	int) Mother 19b. Ma	iling Address (Street	and Number or Rura			e, Zip Code)
and 2	n 27 is ar tra		Mrs. Audrey Butler		Eastship		dalk, Mar		21222
ore es 1.8	if the man are something some in the manager of the		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Remov	annet and an	position (Name of rematory or other pla	ce) D	ate 20c	Location - City	or Town, State
Pag ment	ant: I		4 □ Donation 5 □ Other (Specify)	Hilltop	Service C	corp. 9/13,	/2004 I	owson,	Maryland
Baltimore, permit. Pages 1 ar	important: If ite any injury or of		21. Sign. ure of Funeral Service Licensee	\ / // /	22. Name and Addre Duda-Ruck 1922 Wise	Funeral Ho Ave. Dunc	ome of Du dalk, Mar		nc. 21222
			23a. Part1. Enter the disease, or complication shock, of heart failure. List only one cau	is that caused the death. Do not e	nter the mode of dyir	ng, such as cardiac or	respiratory arrest.		Approximate Interval Between
	sician		Immediate Cause (Final disease or condition resulting in death)	Helatic 6	Encep	folapat	Ly		Onset and Death
	edical miner		resulting in death)	Due to (or as a consequence of):	\.a - ()	100			
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):	100	1001	-		
Tipeling	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
be executed	ician and burial-transil		resulting in death) Last	Due to (or as a consequence of):					
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BOX eath cer	atten for us	cian	in the past 12 months?	Live birth 2 Fetal death 3	☐ Ectopic pregnance	У		23d. Date of o Month	delivery Day Year
j 🖁	by the	nysi		Unknown					
s that	igned to	y P	Part II. Other significant conditions contribut	ng to death but not resulting in the	underlying cause giv	en in Part I.	23e. Did tobaco	o use contribute	to the cause of death?
<b>HECOLOS,</b> he taw requires t	been sig should b		HEROTITIS D				1 🗆 Yes	2 No 3□	Probably 4 Unknown
aw F	2 5	ple	Cella litàs				24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
	pag	Completed	HIV servicità	ře			performed	? death	es 2 No
OT VITAL	certificate rector, paç	Be	25. Was case referred to medical examiner?	ul-	Oth	26. Place of Death	(Check only one)		
Phys O	this al dii	. To	IX tes 2 □ NO	1 Inpatient 2 ER/Outpati		4 Zivarsing Hom	e 5 Residence		pecify)
O ding	After	tion	1   Pending   2   Accident   Acci	n. Date of Injury (Month, Day Year) 28b. Time Injury	Wor	k? Yes 2□No	od. Describe now ii	july occurred	
DIVISION  For Attending after death.	ector: by the	Certification:	2 ☐ Suiside 6 ☐ Could not be	Place of Injury - At home, farm, s	street, factory, office	21	Bf. Location (Street	and Number or	Rural Route Number,
tal or	filled in	Cert	4 - Homicide	building, etc. (Specify)			City or Town, St	110)	
a Hospital	J. Se	Medical	Medical Examiner: O	To the best of my knowledge, dean the basis of examination and/or manner stated.	ath occurred at the tir investigation, in my o	me, date and place, ar pinion, death occurre	nd due to the cause d at the time, date a	(s) and manner and place, and d	as stated. ue to the cause(s)
To tha	To tha complet	Me	29b. Signature and title of certifier	$\sim$	29c. Licens	e number	29d. I	Date signed (Mo	nth, Day, Year)
	- 1		Y / Carlo MA	D	0	CME	Sej	otember	10, 2004
	Λ		30. Name and address of person who complete	ed cause of death (Item 23a) (Type	a, Print)				
	3		31 Date filed (Month Day Years)	23 800	111 Penn	Street, Ba	ltimore,	Marylar	nd 21201
	Sta Registr	-	31. Date filed (Month, Day, Year) SEP 1 3 2004	32. Registrar's Signature	& Span	11			
	7 Rev 1/20	86 A	OLI 1 0 2004	1	- jajoon	K			
				051011	A.1				

			1 - For State Registrer	State of Marylan		artment of H tificate of		Reg	ene 	28859	
	Physici /Medic	cal		les S. Blument	thal				2004 Yea	3:40P M	
* %	Examir	er	4a. Facility Name (If not institution, give 519 Barrymore Dr. 5. Social Security Number 6. Se.		and hirehalass	Oxon Hi	r Location of Death  1 If Under 24 Hrs.		4c. County of De	George's	
- Q-G-	Funeral Director			XM 2□F 80	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, y Jan. 21,	1924 BRC	inthplace (State or Foreign OKLYN, N.Y.	
	72 hours after death with the Maryland neturet', or Items 23s or 28s-f show disal Examinat rust be notified at	Director	10a. State 10b. County  Maryland Prince Go  10e. Street and Number		n Hill			100	. Citizen of What (	10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	ath with	raiD	519 Barrymore Dri	ve		207	45		USA		
980	ours after dei ret', or Items Examiner m	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ∑Yes 2 □ No WWI If Yes, Give Year or Dates:	I   "	Vas Decedent of H f Yes, specify Cuba Pes 2 X No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)	14. Race - An Black, Wh Specify: W	ite, etc.	
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23s or 28a-f show or other traumatic event, the Medical Examiner rust be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) , College (1-4or 5+)	(Give l	lent's Usual Occup kind of work done DO NOT use retired Delegat	during most of wor d)	king 16	b. Kind of Busines State of	s/Industry Maryland	
yland	should be file and Mental Hy s marked oth umatic event	To Be (	17. Father's Name (First, Middle, Last) Sidney Blumer	nthal			18. Mother's Nam Beatr	ne (First, Middle, Ma ice Bra	iden Sumame) aloff		
, Mary	and 2 sho ealth and m 27 Is m		19a. Informant's Name/Relationship (Ty George M. Blument!	na1/Son	3408	Smithvil		ral Route Number, C inkirk,MD.	20754		
imore	Pages 1 ment of He ient: If iter jury or oth		20a. Method of Disposition 1 🛱 Burial 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)	Ce	yland		Cemeter	y 9/13/⊕£⊦		,Maryland	
Balt	permit. Page Department Importent: If eny injury or once.		21. Signature Funeral Service Licens	e.f.	6	160 Oxon	Hill Rd	o.Kalas Fu . Oxon Hil	1, Md. 2		
	nysician /Medical Examiner		23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Myocardial Infarction  a. Myocardial Infarction  Approximate Interval Between Onset and Death Minutes								
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8760,	te be executed ysician and ie burial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
.O. Box 68	death certifica e attending ph d for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year	
s, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions cor Congestive Heart					20		o the cause of death?	
of Vital Record	The law ate has b page 2 sf	Completed	Mellitus					24a. Was an autopsy performer	prior to death?	utopsy findings available completion of cause of	
of Vita	Physician this certifi al director	To Be	A res 2 No	lospital: 1   Inpatient 2   E		1	er: 4 Nursing H	th (Check only one)		ecify)	
Division	ding h. After funel	ertification;									
Div	pital or ours afte lerel Dire	0	4 Homicide determined  29a. Certifier 1 Certifying Physics	28e. Place of Injury - At hor building, etc. (Specify,	)		no data and place	28f. Location (Stree City or Town, S	itate)		
	To the Hospi within 24 hour To the Funer completely fill	Medical	one)	ner: On the basis of examinati and manner stated.	on and/or inve	estigation, in my or	oinion, death occur	red at the time, date	and place, and du	e to the cause(s)	
	wil wil	_	29b. Signature and title of certifier		MD	29c. License D5250	3		Date signed (Mon 3/04	ш, ∪ау, теаг)	
	18		30. Name and address of person who co Shailesh Sheth, M.	D. 1221 Mercan	ntile I	La. Largo	,MD. 207	72			
	Sta Registr		31. Date filed (Month, Day, Year) SEP 13	32. Regisfar's Signatu 2004	J.	book					

			State of Maryland / Deparement of the state of the state of Maryland / Deparement of the state		ental Hygie					
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Lawrence Woodrow Baldwin		2. Date of Death Month	Day Year 3. Time of Death 15:00 PM				
	Examin Funeral		University of Maryland Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death  Caltinua  If Under 1 Year   If Under 24 Hrs.  Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Y	4c. County of Death  Birthplace (State or Foreign Country)				
	Director	}	216-66-6365         1XM 2□F         48         Yrs.           Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Loc;	10/24/19	55 Maryland  10d. Inside City Limits					
336	ith the Maryli or 28e-f sho	Director	MD Harford Havre de		10g	1 X Yes 2 □ No  Citizen of What Country?				
	2 hours after death with the Maryland aturel; or Itams 23a or 28e-f show cal Exemirer mant be notified at	by Funeral	1 Never Married 2 Married 1 Yes 2 M No	21078  las Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto I		JSA  14. Race - American Indian, Black, White, etc.  Specify: White				
Maryland 21215-0036	within 72 ene. than "nal	Completed	(Specify only highest grade completed) (Give killer Differentiary/Secondary (0-12) College (1-4or 5+)	ent's Usual Occupation ind of work done during most of workin O NOT use retired) geration Technicia	ng	b. Kind of Business/Industry  rocery Store				
ryland	should be filed ind Mental Hygi marked other umatic svent, II	To Be C	17. Father's Name (First, Middle, Last)  Herbert A. Baldwin  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	18. Mother's Name  Blanche  Address (Street and Number or Rura	Woodrow					
Baltimore, Ma	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 Is marke eny injury or other treumatic QRCB.		Judith Baldwin- Wife  20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22.	Stokes St., Have the story or other place)  Chap. Cem. 09/08  Name and Address of Facility	re de Grate 20 3/04 Ak	c. Location - City or Town, State				
	Physician /Medical Examiner	ıer	Mitchell-Smith Funeral Home, P.A. Washington, Havre de Grace, MD 2.  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Inmediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Due to (or as a consequence of):							
Box 68760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical Examiner	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year				
rds, P.O.	es that the gned by th be detache	þ	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the unc	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Minknown						
al Records,		e Completed	25. Was case referred to medical		24a. Was an autopsy performe 1 ☐ Yes 2 €					
Division of Vital	anding Physici ath. pr: After this cer ne funeral direc	Certification; To Be	examiner?  1  Yes 2 No	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	me 5 Residence	injury occurred				
Divi	To the Hospitel or Attend within 24 hours after death To the Funerel Director: / completely filled in by the f		28e. Place of Injury - At home, farm, stree building, etc. (Specify)  29a. Certifier  1 Certifying Physicien: To the best of my knowledge, death		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hos within 24 ho To the Fun completely	Medicai	(Check only one)  2 Medicel Examiner: On the basis of examination and/or inversions)  29b. Signature and title of certifier	estigation, in my opinion, death occurre	ed at the time, date	p and place, and due to the cause(s)  Date signed (Month, Day, Year)				
	F 3 F 8		Danny Justy MD	AU4176435		Sept. 3, 2004				
	V		30. Name and address of berson who completed cause of death (Item 23a) (Type, P		MO	21230				
	Sta Registi		31. Date filed Month, Day, Year SEP 13 2004 Flores &	Sperle						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 8. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4,50 **Physician** 2004 Newber Margaret C. Bond /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Glen Burnie Anne Arundel North Arundel Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, You Nov. 18, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** . 1919 Months Days Hours Min. 1 □ M 2 1 F 84 Yrs. 218 05 4964 Virginia Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Show or other traumatic event, the Medical Exerciser countile notified at Glen Burnie Anne Arundel 1 ☐ Yes 2 No Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 7885 Pinewood Drive Apt. 570 or items 23a 21061 U.S. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 Z Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Pages 1 and 2 should be filed within inent of Health and Mental Hygiene. Int: If item 27 is marked other than " Elementary/Secondary (0-12) Nursing Aide Health land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vaness Jenkins Bessie McEaly ္ Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. 6062 Fordham Drive Shelby Township, Michigan 48316 Joseph Eliakis / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 9/10/2004 Baltimore, Maryland ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 nomicain 23a art1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final WULS CM! **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 ☑No the be detached 9 Unknown 9 Unknown signed ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? beter lellotus a 1 Yes 2 No 3 Probably 4 Unknown Be Completed pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 1 Yes 1 ☐ Yes 2 1 No or Attending Physician: filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient Certification: To 1 🗌 Yes 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D4136 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) pital DR. Glen BURNIE, MD M LCKS 301 Hos 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 3 2004 Registrar

04-	-270		For State Registrar	State of	Maryland / Depa	artment of			ene	20062
			Decedent's Name (First, Middle, I	.ast)				2. Date of Death		3. Time of Death
	Physici		Daniel	J. 13	owser	JR.		August	9 2004	10.22 PM
	/Medi Examir		4a. Facility Name (If not institution,			4b. City, Town	, or Location of De		4c. County of Deat	h
			John Hopkins B			$\mathcal{B}$	altimo			
	Funeral			Sex 1 M 2 □ F	7. Age (In yrs. last birthday) 20 Yrs.	If Under 1 Year Months Day			Year) 9. Birt	hplace (State or Foreign untry)
	Director		917-06-0385 Usual Residence of Decedent		20			4-7-	0 7 10171	egracia
	yłano how		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	the Marylan r 28a-f show	cto	Mel.		Baltiv	nore				1 Yes 2 No
	72 hours after death with the Maryland natural', or Itema 23a or 28a-1 show dical Examinar must be notified at	Funeral Director	10e. Street and Number	1	a lo	10f. Zip Code		10	g. Citizen of What Co	untry?
	a 23a	ral	0.7	cky A			213	(Cit-)()	14. Race - Ame	doon Indian
	ter de Item	Ę.	11. Marital Status  1 Never Married 2 Married	Armed For	dent Ever in U.S. 13. ces?	If Yes, specify Cu	uban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Black, White	
036	ours aff	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	e	1 ☐ Yes 2 ☑ N	lo Specify:		Specify: BL	ack,
21215-0036	72 ho	Completed	15. Decedent's (Specify only highest	Education brade completed)	16a. Dece	dent's Usual Occ	supation ne during most of v	vorkina 1.	6b. Kind of Business/	Industry
21	within ene. than "	du	Elementary/Secondary (0-12)	College (1		DO NOT use reti	ne during most of v ired)	1	G F.D.	Program
12	be filed within 72 h tal Hygiene d other than "natu event, the Medical	ပိ	17. Father's Name (First, Middle, La	st)		yvaei		lame (First, Middle, M.		Treespeed.
and		) Be	Daniel J.		er SR,		1,00	er Jone		
Maryland	s 1 and 2 should be filed I Health and Mental Hygi Item 27 is marked other other traumatic event,	ဥ	19a. Informant's Name/Relationship			ng Address (Stre	et and Number or	Rural Route Number,		Zip Code)
	12 a		Inez Jones	(moth	er) 28	14 Ke	n Clerk	Ave. be	Uso. Md.	21213
Baltimore,	es 1 au of Hea f Item r othe		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other p	nlace)		Oc. Location - City or	Town, State
Ē	Page nent c		1 Burial Cremation 3  1 Donation 5 Offer (Specific Speci	口Removal from :	ARBUSTUS		PK 8/	20/04	Bildo. 1.	nd.
alt	permit. Pages Department of Important: If I) any injury or o		21. Signat fe of Funeral Service Lie	9/00	22	2. Name and Add	dress of Facility	639 N. DR	raderly &	were met.
	205 20		1 September 1	pulle	N	iller's 1	Metropoli	tan Chap	D. P.C.	21215
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that cally one cause on e	aused the death. Do not ent ach line.	er the mode of d	lying, such as card	iac or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician (Medical	2	Immediate Cause (Final <sup>7</sup> disease or condition resulting in death)	a GUNS	HOT WOUNDS OF	TORSO				5.1551 2.112 2.5521
	/Medical Examiner	1	rooting in douin,	Due to (	or as a consequence of):					
		ě	Sequentially list conditions, if any, leading to immediate	b. Due to (	or as a consequence of):					
	xecuted and I-transit	Examiner	Cause (Disease or injury that initiated events							
o,	be execu ician and burial-tra	Exa	resulting in death) Last	Due to (	or as a consequence of):					
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d						
9	entifica ing ph e as t	Med	IF FEMALE:			70.2				
Вох	eath certific attending p for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b		Ectopic pregnar			23d. Date of del Month	ivery Day Year
	at the de by the a tached	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9☐ Unkno		Other (specify)				
P.0	res that tigned by	/ Ph	Part II. Dther significant condition	contributing to de	eath but not resulting in the u	nderlying cause	given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds	uires n sign	d by						1 ☐ Yes	s 2. No 3□Pr	obably 4 Unknown
00	sw requir	lete						24a. Was an	24b. Were au	itopsy findings available
Re	The lav	Completed						autopsy perform		completion of cause of 2 ☐ No
Division of Vital Records,	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of D	Death (Check only one		
> >	ys dis	10	examiner? 1∕∑ Yes 2 ☐ No		npatient 2 XER/Outpatier			Home 5 ☐ Resider	nce 6 □Other (Spe	cify)
D C	ding Ph J. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pending		of Injury h, Day Year) 28b. Time o Injury	f 28c. In	york?	28d. Describe how		
Sio	ttendi death. ctor: A y the fu	catl	2 Accident investigat 3 Suicide 6 Could no	be 0,5/		11.1	☐ Yes 2 No		ct shot eet and Number or Ri	um/ Pouto Number
) į	l or Attendafter death Director:	Certification;	4 Homicide determin	ed 286. Place buildir	of Injury - At home, farm, str ng, etc. <i>(Specify)</i> Stre		08	City or Town,	Bank Sts.	Tal Houle Number,
	Hospital or 24 hours afte Funeral Dir tely filled in	<u>S</u>	29a. Certifier 1 ☐ Certifying	Physician: To the	best of my knowledge, deat		time, date and pla			stated.
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Ex	aminer: On the ba and mann	asis of examination and/or in	vestigation, in m	y opinion, death of	ccurred at the time, da	te and place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	^		29c. Lice	ense number	29	d. Date signed (Mont	h, Day, Year)
			( Larken	n()		0	.C.M.E.		August 10	, 2004
	18	ļ Ņ	30 lam and address of person		e of death (Item 23a) (Type,				_	
				(=G, m)			et, Balt:	imore, Mary	yland 2120	1
1	Sta Regist		31. Date filed (Month, Day, Year)  CFD 13 2	004	egistrar's Signature	de				

	6-			State o	f Marylar		artment of I tificate of		l Mental Hy	giene Reg. No. ()	4 2	8863
I	Physici		1. Decedent's Name (First, Middle, La.						2. Date of De Month	ath Day	Year DOLF	3. Time of Death 5:45P7
7	/Medic Examir		K.A. Peter va 4a. Facility Name (If not institution, give	n Berk e street and nui	um nber)			4b. City, Town, o	or Location of Deat			- 70
1	LAGIIIII	ici	Roland Park Place					Baltimo	re			
Ī	Funeral Director		5. Social Security Number 6. S 215-34-7053	ex M 2□F	7. Age (In yrs.	last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	n. (Month, Da	th iy, Year)	9. Birthpla Countr Indo	ace (State or Foreign ry) nesia
	pg a		Usual Residence of Decedent  10a. State 10b. County		100 Ci	by Town or Lo	nation				40	d leside Obs. Unit
	laryla shov	5				ty, Town or Lo					100	d. Inside City Limits 1  Yes 2□No
	the N	ect	MD 10e. Street and Number		Ва	ltimore	10f. Zip Code			10g. Citizen of W	/hat Countr	
	3e or	Funeral Director	4701 East Lane				21210			United		
	death	nera	11. Marital Status	12. Was Dece	edent Ever in U	I,S. 13. V		lispanic Origin?	(Specify Yes or No erto Rican, etc.)		- America	n Indian,
020	be filed within 72 hours after death with the Maryland ntal Hygiene. Be of the marked other than "netural", or items 23e or 28e-f show event, its Medical Examiner must be notified at	ρ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Fo 1 X Yes If Yes, Giv Year or D	2 🗆 No		Yes 2 No	Specify:	erro Hican, etc.)	Specify:	k, White, et White	
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121	filed within Hygiene. ther than "	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)			d)	· · · · · · · · · · · · · · · · · · ·	Private	Prac	tice:
d 2	filed withi Hygiene. Ither than		17. Father's Name (First, Middle, Last)	5+		Physi	.clan	18. Mother's N	ame (First, Middle	Maiden Surnami	e)	
<u>lan</u>	should be nd Mental marked of	To Be	Bernard van B						van de		′	
lan	SPE	_	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	g Address (Street	,	Rural Route Numb			Code)
≥,	CENL		Carla Spawn-van E	Berkum/I				ne, Balt			****	
jore	ges 1 e it of Hea if Item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from		Place of Dispo: cemetery, cren	sition (Name of natory or other pla	ce)	Sep 8	20c. Location - (	City or Tow	n, State
Baltimore, Maryland 21215-0020	permit. Pag Depertment Important: I any injury o		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen	A	Ch		ke Crema		2004	Beltsvi	lle,	MD
Ba	permit. Pages 'Depertment of H Important: if Ite any injury or of once.		21. Signature of Funeral Service Licen	40	Mai	2/		n and Fu	neral Al res Driv			MD
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that cone cause on e	aused the deat ach line.	h. Do not ente	er the mode of dyir	ng, such as card	ac or respiratory a		1	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. As		fus or as a conseq	Preum	onia			9	Onset and Death  2009S
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oʻ	ficete be executed g physician and ss the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	Due to (c	or as a consequ	uence on.	1000		*		
68760,	= 000	Medical	that initiated events resulting in death) Last	c	Due to (o	r as a consequ	uence of):					
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P.O.	0 0 0	yslc	Part II. Other significant conditions co	entributing to de	ath but not res	ulting in the un	derlying cause giv	en in Part I.	23b. Did	tobscco use cop	tribute to t	the cause of death?
	es that the de igned by the a be detached	by Ph	Mueti-Infar	et du	nentie	av .			1 🗆	Yes 2⊡ No	3 □ Proba	ably 4 □ Unknown
Division of Vital Records,	aw requii s been s 2 should	Completed								an autopsy rmed?	avail	e autopsy findings lable prior to pletion of cause eath?
Ě	The ate h	Com							10	res 2 No	1 🗆 '	Yes 2□ No
/ita	ysicien: The is certificate director, pag	Be	25. Was case referred to medical examiner?	l la anital:					eath (Check only o	nne)		
of	S 0 0	.T	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 □ I	npatient 2			4 Larivursing	Home 5 ☐ Resid			
ion	Attending I or death. ector: After by the funer	ation	1 DNatural 5 ☐ Pending investigation	(Mont	h, Day Year)	28b. Time of Injury	28c. Injur Wor M 1 □	yan k? Yes 2∐No	28d. Describe	now injury occurre	a .	
Divis	or Attence efter deatl Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place	of Injury - At hong, etc. (Specif		et, factory, office		28f. Location ( City or Tou	Street and Numbe vn, State)	r or Rural F	Rou <i>te Number</i> ,
	To the Hospital or Attending Phwithin 24 hours efter death.  To the Funerel Director: After thi completely filled in by the funerel	edical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	vsicIsn: To the iner: On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred at the tir estigation, in my o	ne, date and place pinion, death oc	ce, and due to the curred at the time,	cause(s) and man date and place, a	ner as stat nd due to th	ed. he cause(s)
	Vithir To th comp	Me	29b. Signature and title of certifier	^			29c. Licens			29d. Date signed		
	11		M. Tabelle Ma		V			657		Soptemb	er 818	2004
_	1541			REGOR	1830 h	1. 40H	STREET	BALT	TOTORES	70212	//	
		State 31. Date filed (Month, Day, Year) 32. Registrar's Signature egistrar										

DHMH 16 Rev 6/95

			1 - State Amend Item 23a	ate of Maryland / Co., Or., O	epartment of Health and Certificate of Death	Mental Hygie	ne RANI 20061
	Physic	ian	Decedent's Name (First, Middle, Last)			2. Date of Death	Day Yeer 3. Time of Death
	/Medi		Albert	Cloude		September	08 204 2050 M
	Exami	ner	4a. Facility Name (If not institution, give street JOHNS Hopkins Bayure	w Medical Cent		e	4c. County of Death
ē.	Funeral Director		5. Social Security Number 6. Sex 2 1 2 - 4 6 - 9 3 6 1	7. Age (In yrs. last birt.	Adoptho Davis Haves Adia	8. Date of Birth (Month, Day, Ye)	9. Birthplace (State or Foreign Country) 948 Mary Land
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County MD	10c. City, Town	or Location Baltimore	-	10d. Inside City Limits 1ÆYes 2 ☐ No
	n with the 3a or 28a	Funeral Director	10e. Street and Number 5402 Remmell Ave		10f. Zip Code 2 1 2 0 6	10g.	Citizen of What Country?
936	is 1 and 2 should be filad within 72 hours after death with the Maryland of Health and Menta! Hygiene. Item 27 is markad other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evant natural te multified at	by Funera	1 ☐ Never Married 2 🖾 Married 1	as Decedent Ever in U.S. med Forces?  ☐ Yes 2€ ₩0 Yes, Give ear or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☐ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
1215-0036	within 72 hor ene. than "naturi he Wedical E	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted) 16a. pollege (1-4or 5+) S C	Decedent's Usual Occupation (Give kind of work done during most of wor life, DO NOT use retired) aler Attendent	king G	o. Kind of Business/Industry
land 21	should be filad within and Mental Hygiene. s markad other than "umatic evant, I'm Men	To Be Co	17. Father's Name (First, Middle, Last)  Robert Lee Clos	ıde	18. Mother's Nam Shirle	ne (First, Middle, Maid y Lamma	den Sumame)
Maryland	nd 2 shou alth and M 27 Is mar r traumat	-	19a. Informant's Name/Relationship ( <i>Type, P</i> Frederica Cloude/		Mailing Address (Street and Number or Ru 02 Remme11 Ave.		
altimore,			20a. Method of Disposition  15 3 Burial 2 □ Cremation 3 □ Remove  14 □ Donation 5 □ Other (Specify)	al from State cemeter,	Disposition (Name of crematory or other place) ood Cemetery	6-04	Location - City or Town, State  1 timore, Maryland
Balti	permit. Page Department of Important: If any njury or once.		21. Signa ure co Puneral Service to Insee	the	22. Name and Address of Facility Ta	ylor's F	
68760,	The law requires that the death certificate be executed has been signed by the attending physician and care and page 2 should be detached for use as the buffal-transit	edical Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.  Sequentially list conditions.  b		ot enter the mode of dying, such as cardiac  Cal Hemorphage f):	or respiratory arrest,	Approximate Interval Between Onset and Death Interval Ours
O. Box	that the death certifi ed by the attending I detached for use as	Physician/Me	in the past 12 months?	yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
of Vital Records, P.	aw requires that is been signed b 2 should be deta	Completed by Pf	Part II. Other significant conditions contribut  Anticoagulation -			1 ☐ Yes 24a. Was an	2 No 3 Probably 4 Monknown
tal Re		е Сош	25. Was case referred to medical		20.8	autopsy performed	
ί	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No Hospita	al: 1 Inpatient 2 ER/Outp	O++ +	th (Check only one) ome 5 - Residence	6 ☐Other (Specify)
ion o	<u>a</u> = <u>a</u>		27. Mannar of Death  1 Natural 5 Pending 2 Accident investigation	a. Date of Injury (Month, Day Year) 28b. Ti		28d. Describe how in	
Division	or At fter o	Certification:	3 Suicide 5 Could not be determined 28	e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
L	To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	edical (	(Check only 2 Medical Exeminer: C	: To the best of my knowledge, n the basis of examination and nd manner stated.	death occurred at the time, date and place, for investigation, in my opinion, death occur	and due to the cause red at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
1	To the vithin To the comp	Me	29b. Signature and title of certifier	wat	29c. License number  7 0 9 9 9	29d. [	Date signed (Month, Day, Year)
	(i)		30. Name and address of person who complete	A	5.0	1 111	71104
	Sta	te	AI Sakonju, MI) 31. Date filed (Month, Day, Year)	32. Registrar's Signature	Hern Avenue, Ball	more MI)	21224
	Registr		SFP 1 3 2004	Bleeve D.	Rosel		

		For State Registrar		State of	Marylar				lealth a Death		lental H	ygiei Reg.	200	104	288	965
Dharini		1. Decedent's Name (First, Midd	fle, Last)			<del></del>				Ī	2. Date of I	Death	Day	Year	3. Time of	Death
Physici /Medio		Mary Ade					,				Sept.	7,	2004		6:10	₽M
Examir	ier	4a. Facility Name (If not instituti					4b. City		Location of				4c. County			
Funeral		Sommerville 5. Social Security Number	ASS1		. <b>1V1N</b> G 7. Age (In yrs.	last birthday)	If Unde	WES r 1 Year	tmins If Under		8. Date of I	Birth		rrol]	place (State o	r Foreign
Director		213-12-B269 Usual Residence of Decedent	10	M 2√2 F		83 Yrs.	Months	Days	Hours	Min.	Jan. E			Cour	yland	
within 72 hours after death with the Maryland one. Than "natural", or itams 23s or 28a-f show ha Madical Evantinar must be notified at	ō	10a. State 10b. Count			10c. Ci	ty, Town or Lo								1	1 ☐ Yes	1
28a-	Director	Md. [	arro	111	1		ມ <mark>່estm</mark> 10f. Zi	INSt Code	er			10g.	Citizen of	What Cour	ntrv?	
38 of 18		45 Washingto	n Ro	aď				2	1157					USA	•	
rai', or itams 23s or 28a-1 show Examinar must be notified at	y Funeral	11. Marital Status 1 Never Married 2 Ma	rned 1		2 [X] No		Was Dece If Yes, spe		ispanic Ori in, Mexican Specify:		city Yes or l Rican, etc.)	No-	14. Rad	ce - Americ ck, White,		
"natural", dical Exz	ted by	3 Widowed 4 □ Divorce 15. Decede	nt's Educ	Year or Da	ites:	16a. Dece	dent's Usi	ial Occupa	ation			16b		lusiness/In	hite dustry	
jiene. r than "natur Ina Medical	Completed	(Specify only high Elementary/Secondary (0-12)	est grade	College (1	-4or 5+)	life.	DO NOT L	rk done d ise retired kkeet	•	t of works	ng		0 -		•	
Hygiene. other than ent, the M	0	17. Father's Name (First, Middle	, Last)				٥٥٥	KKEE		er's Name	(First, Mida	le, Maio		count	ing	
rked c	To B	Cleveland R	lober	t Hoke						Anne	es Ros	ensi	tee 1			
ls marked o		19a. Informant's Name/Relation				19b. Maili	ng Addres	s (Street a	an <i>d Numb</i> e	_	l Route Nun			State, Zip	Code)	
t Health and Mental Hygitam 27 is marked othe other trsumatic event,		Mr. Robert Cour	sey/	Son	20b. I	2010 Place of Dispo			ive		tminst			land - City or To		
		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (		emoval from S	State	cemetery, crei	matory or	other plac	1					•		
Department of important: if it any injury or o		21. Signature of Funeral Service		104-	S/		2. Name a	nd Addres	n, Gress of Facilit Road	y Ruc		son	Fune	ral H	lome, I	
ophsician and pural-transit the printing of th	ledicai Examiner	23a. Part1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. b.	Due to (	or as a consector as	- Cer quence of): quence of):	elen nati	es or dyin	such as	in l	icer h.	Lin	t		Approximate interval Between Sonset and Communications and Communication Sonset and Communication Sonset and Communication Sonset Sonse	ween
ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	23	1 Live bi	come of pregninth 2 Feta ant at time of cown	al death 3[	⊒Ectopic p □ Other (s							ite of delive	-	'ear
B 8	by	Part II. Other significant condi-	ions con	tributing to de	ath but not res	sulting in the u	nderlying	cause give	on in Part I.	•			o use cont		ne cause of de	
cate has been s page 2 should	Completed											opsy formed	?	prior to cor death?	psy findings a npletion of ca 2 \( \text{No} \)	ivailable iuse of
iis certifica director. p	Be	25. Was case referred to medic examiner?		ospital:				Othe			Check on	_	*1		Gran	tit
this aldin	1: To	1 Yes 2 No		28a. Date o		ER/Outpatier 28b. Time o		DA Cure	at Nu		ne 5 🗆 Re 28d. Describ			ier <i>(Specif</i> ) red	Ines	ny
seath. tor: After the funer	ation	1 Natural 5 Pend 2 Accident inves	tigation	(Monti	h, Day Year)	Injury	М	28c. Injury Work 1 🗀 `	(? Yes 2 □ I			7 7.0 77 11.	ilan oodar		327	•
n by	Certification;		mined	28e. Place buildin	of Injury - At h	iome, farm, sti fy)	reet, factor	y, office		1	28f. Location City or T			er or Rura	l Route Numb	)9 <i>r</i> ,
z4 nours a • Funersi D • etely filled i	dicai	29a. Certifier 1 Certify (Check only one) 1 Medica	ing Phys I Examin	ician: To the er: On the ba and mann	best of my knows is of examination stated.	owiedge, deat ation and/or in	h occurred vestigation	at the tim	ne, date and pinion, deat	d place, a th occurre	and due to the	e cause e, date a	(s) and ma and place,	anner as st and due to	ated. the cause(s)	
within 2 To the complete	Me	29b. Signature and title of certif	er				29	c. License	number			29d. [	Date signe	d (Month,	Day, Year)	
		1 4 hm	W	m	red	lution		DZ	-54	43		9	191.	7 404	1	
Of		30. Name a ddress of perso	who cor	mpleted cause	of death (Iter	m 23a) (Type, Poole ature	Print)			. 1		700	1.00			
,		31. Date filed (Month, Day, Yea	dell	eton	688 ;	roole	Ko	ad,	W.	estn	nmjj	er	VV	しりン	1157	
Sta Registr		SFP 13			egistrar's Sign	ature		2								

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H		-	ene g. NS. () () ()	28866
	Sti.i		1. Decedent's Name (First, Middle, Las					2. Date of Death Month		3. Time of Death
	Physicia /Medic		DONALD L.		ERBUCK	· · · · · · · · · · · · · · · · · · ·		Septembe	er 9, 2004	
	Examin	er	4a. Facility Name (If not institution, give	street and number) MANOR			Location of Death	m, MD, 21204	4c. County of Dea	
	Funeral		DULANEY TOWSON  5. Social Security Number 6. S		ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign
	Director			M 20F 7	FO Yrs.	Months Days	Hours Min.	11-23-1	933 C	Maryland
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryla f sho	ro	Maryland				Baltimore	9		1XXYes 2 ☐ No
	n the	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	23a c	Funeral Director	2010 Rockrose Av	re.			211		United	
	er des items nar m	une	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
036	urs aft	Þ	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 (XYes 2 □ I If Yes, Give Year or Dates:	(Unknown)	1 ☐ Yes 2 No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or liems 23a or 28a-f show the Madical Examinar must be notified at	Completed	15. Decedent's Ec	ducation	16a. Dece	dent's Usual Occupa	during most of wor	king 1	6b. Kind of Business	/Industry
121	within han "	mple	Elementary/Secondary (0-12)	College (1-4or	life.	ACHINIS	)		Corroseem	ont
N	filed v Hygie other 1	CO	17. Father's Name (First, Middle, Last)		711	7,011.110		ne (First, Middle, M	Governm Maiden Sumame)	ent
an	buld be Mental arked o	To Be	Charles Will	iam Cl	atterbuck		Ida	Annn	Evans	
⊭	and and is m		19a. Informant's Name/Relationship						City or Town, State,	Zip Code)
	1 and 1 Health tem 27		Trema Hoffman / [ 20a. Method of Disposition	)aughter		A Burton			e, MD 21	093
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other ance.		1 ☐ Burial 2 ☒Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specific			osition (Name of matory or other plac ce Cremato	1001	ot. 13, 2		
ati.	permit. P Departme Importan any injuri once.		21. Signature of Funeral Service Licer	1600_	2	2 Name and Addres	s of Facility		Beltsvil	
ä	Depa Impo any ii		> Stephen do	luman	M06382 C	AFA Steph 717 Green	en D. Lo Pasture	hrmann P. s Dr., Ba	A. Itimore,	MD 21286
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	d the death. Do not en	ter the mode of dyin	g, such as cardiad	or respiratory arre	st,	Approximate Interval Between Onset and Death
27	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Q	noterite	perpo	tic C	encer		Gridor and Godin
	Examiner			- 1	a consequence of):	A Ponce				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	U	a consequence of):	1100 114				
	and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. fr	Seanso	Peelin	re			
8760,	death certificate be executed e attending physician and nd for use as the burial-transit		rossning in south, Edst	Umm	a consequence of):	nelm	Inlm	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	Posian	
687	fficate g phys	Physician/Medical		_ d						
Вох	leath certific attending pl	M/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		⊒Ectopic pregnancy			23d. Date of de	
В	ne deat the att hed for	sick	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown		Other (specify)			Month	Day Year
P.O.	that the de ed by the detached		Part II. Other significant conditions of	ontributing to death t	out not resulting in the o	underlying cause give	en in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
Division of Vital Records,	sign sign d be	d by			-			1 🗆 Yes	s 2 □ No 3 □ P	robably 4 Unknown
CO	aw requast been 2 should	Completed						24a. Was an	24b. Were a	utopsy findings available completion of cause of
Ä	The ate h page	Com						perform	ed?   death?	s 2□ No
Vita	Physician: Th rhis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		ot 300 DOA Othe	0.00	th (Check only one	·	
o	di is	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ∐ Inpatio	ury 28b. Time o	of 28c. Injun	/ at	ome 5 Resider 28d. Describe how	nce 6 Other (Spe winjury occurred	ocify)
ion	Attending if death.	atlor	1 Netural 5 ☐ Pending 2 ☐ Accident investigation	( <i>Month, D</i> a	ny Year) Injury	Worl M 1□	<br Yes 2 ☐ No			
i⊼is	l or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of III)	jury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
Ω	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Ph	veicine: To the heet	of my knowledge, dea	th against dat the tin	no, data and place	and due to the car	use(s) and manner a	e ctated
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	(Check only 2 Medical Exer	niner: On the basis o and manner st	of examination and/or in	nvestigation, in my o	pinion, death occu	rred at the time, da	te and place, and du	e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	0	lad a	29c. License		29	d. Date signed (Mon	
•	. (		1800Ma	~	Mn	D	1464		9/11/01	1
	241		7 - 111	n1 821	N. Enter	~ St	Sonte 3	of 13al	t.mo	21201
	Sta Registi		31. Date filed (Month, Day, Year) SEP 13	2004 32. Abgistr	rar's Signature	park				

			1 = For Stata Ragistrar	State of Mai	-	epartment of Certificate of			giene Reg. No:- 0 0 4	28867
			1. Decedent's Name (First, Middle, Last	)	Λ	11		2. Date of De	ath	3. Time of Death
	Physici /Medio		Makaia		Ca	rroll		Aug.	30 20	09 2310 M
	Examin	er	4a. Facility Name (If not institution, give HOWARD Com	ity Gen	Hosp	4b. City, Town,	imbio		4c. County of Dea	and-
	Funeral Director		5. Social Security Number 6. Se 10	x 7. Age □M 2X1F	(In yrs. last birth Yı	Months Days		Min. 8. Date of Bir	th 9. Bi	rthplece (State or Foreign
	pu >		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town			111-01.	,	
	Maryla f shov	or	MD Howar		-	lumb <b>i</b> a				10d. Inside City Limits 1 ☐ Yes 2 No
	r 28e-	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	th wit	alD	4812 Circling Hu	nter Drive			2104.	5	USA	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Instruction: If item 27 is marked other then "neturel", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examination ust be invilled at once.	by Funeral Director	11. Marital Status  1 → Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	er in U.S.	<ol> <li>Was Decedent of If Yes, specify Cu</li> <li>Yes 2 No</li> </ol>		n? (Specify Yes or No Puerto Rican, etc.)		
Maryland 21215-0036	ithin 72 ho	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0·12)			Decedent's Usual Occu Give kind of work done ife. DO NOT use retir	during most o	f working	16b. Kind of Business	s/Industry
7	fled w flygier her th		none r 17. Father's Name (First, Middle, Last)	ione	no	ne	10 Mathada	Name (First Minute	none	
and	ld be fi ental F ked of	To Be	Damon Owens	Carrol1				s Name <i>(First, Middl</i> e, Cole M. Ra		
ary	2 should and Men Is marke aumatic	F	19a. Informant's Name/Relationship (T)	vpe, Print)	19b. N	Mailing Address (Stree			er, City or Town, State,	Zip Code)
	and 2 ealth a m 27 I		Howard County Gene	eral Hospit		55 Cedar I	ane Co	- Contract		
Baltimore,	Pages 1		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 🖾 Other (Specify,	in state	cemetery,	Disposition (Name of crematory or other pl.	ace)	Date	20c. Location - City or	r Town, State
Ball	permit. Departr Importe any inju		21. Signature   Fundral Service Licens	// Lexx			omy Boa MD 21		Baltimore	Street
	Physician		23a. Part Enter the disease, or comb shock or heart failure. List only o immediate Cause (Final disease or condition	ica <del>tio</del> ns that ceused the cause on each line.	atous	t enter the mode of dy	ing, such as ca	rdiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Sequentially list conditions,	expe	consequence of	premate	nity			1 hour
	cuted nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a company)	inal	mcompe	knt	cerving		1 hour
8760,	cate be executed physician and the burial-transit	dlcai Ex	resulting in death) Last	Due to (or as a od.	consequence of	: 				/
.O. Box 6	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  \( \text{Yes} \) 8 2 No 9 \( \text{Unknown} \) Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	cy		23d. Date of de Month	livery Day Year
Δ.	uires that I signed by Id be deta		Part II. Other significant conditions co	ntributing to death but	not resulting in ti	he underlying cause g	ven in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
Records,	he law requir e has been si ige 2 should	Completed						24a. Was autop perfo	rmed?   death?	utopsy findings available completion of cause of
Vita	ilcien: Th certificate rector, pag	a	25. Was case referred to medical				26. Place of	1 ☐ Yes Death (Check only o		3 2□No
	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 XNo	lospital: 1X Inpatient	2 ER/Outp	atient 3 DOA	har		dence 6 Other (Spe	ocify)
Division of	Attending Physicien: r death. ector: After this certific. by the funeral director,	ertification;	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day )	(e <i>ar)</i> 28b. Tin	ıry Wo	iry at ork? ]Yes 2. ☐No		now injury occurred	
<u>Š</u>	afte Dir	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm (Specify)	n, street, factory, office		28f. Location (S City or Ton	Street and Number or R vn, State)	ural Route Number,
	Hospi 24 hou Funei stely fil	Medical	29a. Certifier (Check only one)	sician: To the best of one: On the basis of example and manner state	xamination and/o	death occurred at the tor investigation, in my	ime, date and p opinion, death (	place, and due to the o occurred at the time, o	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To the Hospital or within 24 hours afte To the Funeral Director Completely filled in the	Me	29b. Signature and title of certifier	and manner state	<b>J</b>	29c. Licen	se number		29d. Date signed (Mont	th, Day, Year)
	0		marenta	Yatron	, mi		115-98	?	Sept, 3	2004
			30. Name and address of person who co	ompleted cause of dea	th (Item 23a) (T)	(pe, Print) Da ha	xent	Ptuna	Columbi.	n A
	Sta	ie	31. Date filed (Month Pay Year)	32 Registrar's	Signature	ie jain	ran	ray	Coe unne.	a mi
	Registr		31. Date filed (Month Pay 1 9 200	Colore	K	land.				

			1 - For State Registrar	State of Mary	rland / Depa	artment		nd Mental Hy	giene Reg. No.	28868
è.	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Las     Fletcher Carpe      4a. Fecility Name (If not institution, give     Manor Care Rux	nter street and number)			own, or Location of (		ber 5, 2	
	Funeral Director		Social Security Number 6. S	7. Age (In	yrs. last birthday) 9 Yrs.	If Under 1		Hrs. 8. Date of Birt (Month, Day Aug 10	h v. Year)	timore 9. Birthplece (State or Foreign Country) North Carolin
	the Maryland 28a-1 show	Director	10a. State 10b. County MD Baltimo		c. City, Town or Lo		ode		10g. Citizen of Wh	10d. Inside City Limits 1 Tyes 2 No
8	d within 72 hours after death with the Maryland piene. Than "natural", or iteme 23a or 28a-f ehow the Madical Evaminat must be maillied at	Funeral	7001 N. Charles S  11. Marital Status  1 Never Married 2 Married	Street  12. Was Decedent Ever Armed Forces? 1	1		212 nt of Hispanic Origin Cuban, Mexican, F		USA 14. Race Black,	- American Indian, White, etc.
1213-00	within 72 hours ene. than *neturel', the Moulcel Exi	Completed by	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Ed (Specify only highest grade  Elementary/Secondary (0-12)	Year or Dates:  Judation Jude completed)  College (1-4or 5+)	16a. Decec	fent's Usual (	Occupation done during most of	working	16b. Kind of Busi	black ness/industry
שמ	be file ital Hyg od othe event,	To Be Co	12 17. Father's Name (First, Middle, Last) Willie Carpen	ter		stone		Name (First, Middle,		sonery unl
E, Mai	d 2 s th ar 7 le trau		19a. Informant's Name/Relationship (T. Michelle Augustus) 20a. Method of Disposition	s/daughter	706 Ob. Place of Dispo	Winans sition ( <i>Name</i>	Way Balt	r Rural Route Numbe Cimore, MD	r, City or Town, St 21229 20c. Location - Ci	
	permit. Pages 1 an Department of Heali Important: If item 2 any injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☒ Other (Specify, 21. Signature 1 ☐ Funeral Struige License Cl. Struige License C	Removal from State 7	cometery, cren	. Name and A	Address of Facility	ard 655 W.		
,00,	te be executed /Medical /Medical Examiner	edical Examiner	23a. Part Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cord	death. Do not enter  The Third This equence of):  Sequence of):	or the mode of	of dying, such as car	1201		Approximate Interval Between Onset and Death
	rife raw requires mar the death derthics ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 [	Ectopic pregi Other (speci			23d. Date of Month	
(50,000)	w equires that been signed by should be deta	þ	Part II. Other significant conditions co	ntributing to death but no	t resulting in the un	derlying caus	se given in Part I.	23e. Did tol		ate to the cause of death?  ☐ Probably 4 ☐ Unknown
Alter His	certificate has l	e Completed	25. Was case referred to medical				OC Pinn of	— 24a. Was a autops perform 1 ☐ Yes 2	ned? dea	re autopsy findings available r to completion of cause of th?  Yes 22 No
,	this	To B	examiner?	lospital: 1  Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of Injury		Ott	g Home 5 🗆 Reside		(Specify)
	trospitation activations 24 hours after death. Funeral Director: After tely fitted in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	pecify)			City or Towr	n, State)	or Rural Route Number,
4	vithin 24 hours a lo the Funeral I	Medical	29a. Certifier 1 Check only 2 Medical Exami one)  29b. Signature and title of certifier  ■ Walls	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, death nination and/or inv	estigation, in	he time, date and pl my opinion, death o cense number	ccurred at the time, da	ause(s) and manner ate and place, and 9d. Date signed (A	due to the cause(s)
	Sta Registr		30. Name and address of person who or WT-Ten Lappn E 31. Date filed (Month, Day, Year) SEP 1 3 20	25 32. Aggistrar's S	Cituro	rint)  if LA	Hos	S, MD	21082	<u> </u>

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Month FRANK DUBIEL Ő9 11:01 P M 06 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 23,1929 **Funeral**  Birthplace (State or Foreign Country) Days Months Hours 1 € M 2 □ F Min. Director Vrs 220-22-2650 Maryland Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits treumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1645 Gray Haven Court 21222 United States items 23e Pagas 1 and 2 should ba filed within 72 hours after death nent of Health and Mental Hygiene. int: If item 27 is marked other than "neture!", or items 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1X☐Yes 2☐No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 🏂 No Specify: Specify: White 3x Widowed 4 □ Divorced Korean 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Years Millwright Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Dubiel Albina Balcer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pagas 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tret QDCE. Michelle Biedenkapp/Daughter 1801 Redfield Road Bel Air, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 9/13/2004 Towson, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** me resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or injury Due to lor as a consequence of The law requires that the death certificate be axecuted as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9□ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed 3 Probably 1 Tyes 2 No 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy page performed? Division of Vital 1 Yes 1 Yes 2 No 8 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other. 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred After 1- | Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 65 D3552) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+WA 615 W. MacPHAIL ROAD, BEL AIR, MD DAVID S. DUNN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Sporks Registrar

			For State Registrar	State of M	aryland		artment of F		and M		iene	4 6	28870
			1. Decedent's Name (First, Middle, I	Last)						2. Date of Dear	th		3. Time of Death
	Physici /Medio		M. Ambrose	Dunn						Month 09	Day 2.00	Year )4	9:40p M
ki -	Examir		4a. Fecility Name (If not institution, g				4b. City, Town, o	r Location o	f Death		4c. County o		7.40p
			4100 Maple Av					imore			Ba1	imore	
	Funeral			. Sex 7. Ag 1		ast birthday) Yrs.	If Under 1 Year Months Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day March 2	Year)	9. Birthplac	e (State or Foreign
	Director		199 40 7525 Usuel Residence of Decedent		92	115.				March 2	4,1912	Penns	sylvania
	/land		10a. State 10b. County		10c. City	, Town or Lo	ocation					10d.	. Inside City Limits
	Mary First	Ď	Maryland Balti	more	Ba	altimo	re						1 ☐ Yes 2X No
	r 28s	rec	10e. Street and Number				10f. Zip Code			1	0g. Citizen of Wi	nat Country	?
	th wit	atD	4100 Maple Ave	nue			212	27			U.S.		
	ema erm	<b>Funeral Director</b>	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Decedent of H	lispanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		American White, etc	
36	or It	by Fu	1 X Never Married 2  Marned	If Yes, Give	No		1 ☐ Yes 2X No	Specify:		act to	1000	White	
21215-0036	be filed within 72 hours after death with the Maryland lat Hygiene. diother than "natural", or items 23s or 28s-1 show event, the Medical Examinar must be notified at		3 Widowed 4 Divorced	Year or Dates:		160 Dass	dani'a Hawal O						
5	in 72	Completed	15. Decedent's (Specify only highest of	grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most	t of worki	ng	16b. Kind of Bus	iness/indus	stry
77	within iene.	шо	Elementary/Secondary (0-12)	College (1-4or !	5+)		son & Ho	•	s Mi	nistry	Religi	ous S	ister
	e filed within al Hygiene. I other than vent, the Me	BeC	17. Father's Name (First, Middle, La	st)				18. Mothe	r's Name	(First, Middle, I	Maiden Sumame		
<u>a</u>		To B	John D	unn					Jose	ephine E	Brazi1		
Maryland	" = m =		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street	and Numbe	r or Rura	il Route Number	City or Town, S	tate, Zip Co	ode)
	and 2 salth a n 27 is		Sister Mary Be	cker		4100	Maple Av	enue	Ba	altimore	, Maryl	and 2	1227
ore	iges 1 an of Heal I Item 2 or other		20a. Method of Disposition  1 XBurial 2 Cremation 3	□Removal from State	20b. PI	ace of Dispo	nsition (Name of matory or other place	сө)	С	ate	20c. Location - C	ity or Town	, State
<u>Ĕ</u>	mit. Pages bartment of loortant: If Its injury or o		'4 □Donation 5 □Other (Spec		New	Cath	edral Cem	1.	9/9/	2004 1	Baltimor	e, Ma	ryland
Baltimore,	permit. Pages Department of I Important: If It any injury or o		21. Signature of Funeral Service Lig	ensee		16.3	2. Name and Addre		GO	nce Fune	eral Ser	vice,	P.A.
	ā O E a d		Marie M	granus	ella		001 Ritch					-	and 21225
H			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mblications that caused one cause on each li	i the death ne.	. Do not ent	er the mode of dyir	ng, such as				Int	oproximate terval Between nset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_aCOI	rge.	Struck	Ha	V-T	10	ic we			Tool and Dogin
	/Medical Examiner		rooting in abany	Due (or as	a c equ	ience of):							
0.3		<u>-</u>	Sequentially list conditions, if any leading to immediate	b. Due to for as	a consucu	ensa of):							
	nsit	nin.	cause. Enter Underlying Cause (Disease or injury	(3)	100		ancer						
Ć,	execun n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequ				<del></del>				
3760,	ate be executed hysician and the burial-transit	catl		d.									
3	ifficat g phy as th												
Box	death certifical e attending phy d for use as th	J/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy	,			23d. Date	of defivery	
B	0 0 0	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at			Other (specify)				Monti	n Da	y Year
P.O.	res that the death cer igned by the attendin be detached for use	Physician/Med	9 Unknown										
Ś	The law requires that the ate has been signed by the bage 2 should be detache	by	Part II. Other significant conditions	contributing to death b			nderlying cause giv	en in Part I.			acco use contrib		
ord	w requir been si should	Completed	1 igenizes	Spront		7 na	, , , ,			1 🗆 Y6	s 2 No 3	☐ Probably	y 4 🗆 Unknown
ec	elaw hasb je2sh	nple								24a. Was ar autops	y pri	or to comple	findings available etion of cause of
H		Co								perform		ath? ]Yes 2[	No
Vital Record	Physician: The this certificate all director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		of Death	Check only on	9/		
of	Phys this al dir	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		ER/Outpatier 28b. Time of	ot 3 DOA Oth	4 🗆 1401			nce 6 Other		
UC	Jing After fune	lon	1 Natural 5 ☐ Pending	(Month, Da		Injury	Wor	yai k? Yes 2.⊟N		zod. Describe no	w injury occurred		
Division	Attending r death. ector: After by the funer	ficat	3 ☐ Suicide 6 ☐ Could not	be 29a Blace of Ini	urv - At hor	me farm str	eet, factory, office	163 2		28f. Location (St	eet and Number	or Rural Ro	nute Number
<u>S</u>	after Dire	Certification:	4 ☐ Homicide determine	building, et	c. (Specify,	)	Col, Idolory, Onioo			City or Town		011111111111111111111111111111111111111	Solo Hambor,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying	Physician: To the best	of my knov	viedge, death	n occurred at the tir	ne, date and	d place, a	and due to the ca	use(s) and manr	er as state	d.
	n 24   n 24   ne Fu	edical	(Check only 2 Medical Ex	eminer: On the basis of and manner sta	f examinati	ion and/or in	vestigation, in my o	pinion, deat	h occurre	ed at the time, da	ite and place, an	d due to the	e cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier		Atto	ende	29c. Licens	e number		29	d. Date signed (	Month, Day	, Year)
7	2		(Dam Co	un So	Ph	4 Stan	in I	)30	63	1	9/7/0	4	
	/		30 Name and address of person wh	The Part of the Pa		23а) (Туре.	Print)				10	11. 1	CC1 C 12
			Mittlan Ke	isingers.		ui)	100	Gei	pe /	(d)	CA-15-702	ue,	2515 CM
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registr	ar's Signati	ure Anas	Es.			6			

				1 - For State Registrar		State o	of Maryla	-	artment <i>rtificate</i>		alth and Neath	Mental Hy	giene Rog. No. (	101	20071	
		Physicia	an	1. Decedent's Name (Firs		•						2. Date of De	eath Day	Year	3. Time of Death	
		/Medic	al	Andrew Deln  4a. Facility Name (If not is			mber)		4b. City. T	own, or L	ocation of Death	Septem		, 2004 ounty of Dear	12:11 PM	-
		Examin	eı	Gilchrist H	ospice				T	OWSOI	n		В	altimo		
		Funeral Director		5. Social Security Number 214 30 6453	11	x XM 2□F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Months	Year Days	Hours Min.	8. Date of Bi (Month, Di Dec. 17	rth a <i>y, Year)</i> 7 <b>,</b> 1933	9. Bird Co Mar	thplace (State or Foreign ountry) cyland	1
	Vand	yland now		Usual Residence of Dece 10a. State 10b.	County		10c. C	City, Town or Lo	ocation						10d. Inside City Limits	_
	eM ec	8e-f st	ector		rford			Stree							1 □ Yes 201 No	
	with t	3e or 2	Dir	10e. Street and Number 3025 Dublin	Rd.				10f. Zip 0	1154			10g. Citize	n of What Co A	ountry?	
	6 after death	is Tand 2 should be filed within 72 hours after beart with the maryland if the market had been the market filed 27 is marked other then "neturel", or items 23e or 28e-f show other treumatic event, the Medical Evantuar must be notified at	Funeral Director	11. Marital Status 1 Never Married 2	Married	Armed Fo	edent Ever in lorces? 2 \( \text{No}\) No lorces: 1956		Was Decede	fy Cuban,	panic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		. Race - Ame Black, Whit		
	-003	turel',	ed by	3 □ Widowed 4 🛣 🗓	Divorced Decedent's Ed		Dates: 1956		dent's Usual					of Business		
	21215-0036	hen "ne hen "ne	Completed	(Specify on Elementary/Secondary	ly highest grad	de completed) College (		(Give	kind of work DO NOT use	done dui retired)	ring most of won	king		struct		
	d 2	Hygiel other the	O	17. Father's Name (First,	Middle, Last)			Cal	rpente		8. Mother's Nam	ne (First, Middle			.1011	
	Maryland	Menta Menta Marked	To B	William Fraz							Mamie B					
	Mar	ind 2 sn lith and 27 is rr r treum		19a. Informant's Name/F Diana Hensle							d Number or Ru Baltin				Zip Code)	
	Baltimore,	l of Heal		20a. Method of Disposition		Removal from	State	Place of Dispo	matory or oth	ner place)		Date		tion - City or		
	Itim	permit. Pages Department of h Importent: If ite any injury or of		4 □ Donation 5 □ 21. Signature of Funeral			HO							imore,	Maryland	
	Balt	Depar Impor		John 9	V. Be	vikou	ske	ļ	Bruzdz 1407 o	insk ld E	of Facility i Funera astern A	al Home Avenue I	P.A. Essex,	Md. 2	21221	
				23a. Part 1, Enter the dis shock, or heart failu Immediate Cause (Finat	ease, or comp ire. List only o	olications that one cause on	each line.								Approximate Interval Between Onset and Death	
		nysician /Medical		disease or condition resulting in death)	-	aDue to	(or as a conse	equence of):	- pro	217	TTE (	Carke	32_		years	_
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	58760, ficate be executed	sician and burial-transit		resulting in death) Last	l	Due to	(or as a conse	equence of):								
m	687 rtificate	phy s the	Medical	IF FEMALE:		u.							-	Ì		
1211	O. Box 6	the attending property of the attending prop	Physician/Me	23b. Was decedent preg in the past 12 montl 1  Yes 2 No	nant	1 Live	itcome of pregr birth 2 Fe nant at time of nown	tal death 3	□Ectopic pre □ Other (spe				236	d. Date of del Month	ivery Day Year	
hop	S, P.	igned by the	by Ph	Part II. Other significant	conditions co	ontributing to o	leath but not re	sulting in the u	ınderlying ca	use given	in Part I.	23e. Did	tobacco use	contribute to	the cause of death?	
46	ecord	been sig											Yes 2□I		. ,,	
٤	CC 2	ate has t	Completed									24a. Was auto perfe 1  Yes		246. Were at prior to death?	utopsy findings available completion of cause of	'
hazira	Vital	ysicient: Title is certificate ha director, page	o Be	25. Was case referred to examiner? 1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \)	-	Hospital:	Inpatient 2[	7.50/0	-1 200	Other	26. Place of Dea		- 4	<b>6</b> 1 1 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1	- Woonico	7.7
3	n of	After this funeral di	F :	27. Manner of Death	Pending	28a. Date		28b. Time o Injury		c. Injury a Work?	4   Nulsing I	28d. Describe			cify) Hospice	
3	Division Division	after death. Director: A	ertification;	2 Accident 3 Suicide 6	investigation Could not be determined		e of Injury - At	home, farm, st	M reet, factory.		s 2 No	28f. Location (	Street and I	Number or Ru	ural Route Number,	
Andrew	Div	rs after el Dire	O	4  Homicide	determined	build	ling, etc. (Spec	cify)				City or To	wn, State)			
4	Hospi	within 24 hours at to the Funerel I completely filled	edicai	29a. Certifier (Check only one)	Certifying Phy Medical Exam	iner: On the b	e best of my kr pasis of examination of stated.	nowledge, deat nation and/or in	th occurred a rvestigation, i	t the time, n my opin	, date and place, nion, death occur	and due to the rred at the time,	cause(s) ar date and pl	nd manner as ace, and due	stated. to the cause(s)	
	To the	within 2. To the I complet	Me	29b. Signature and title of	of certifier	0			29c.	License (		,			h, Day, Year)	
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	D	)		30 Name and address of	inarles	5 mp								harles • 2120	Street	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 9, 2004 **Physician** Rebecca Lee Fry 9:30 am M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 358 Catoctin Avenue Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug. 1938 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 212-38-7519 66 Marviand Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f shov Tre Madical Exercit er must be retified at Maryland Frederick Frederick 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 358 Catoctin Avenue 21701 U.S.A. death v Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes XXNo If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married o. Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Secretary-Treasurer Construction Company traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lewis Howard Renn, Sr. Bessie M. Stimmel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl L. Fry, Sr., husband 358 Catoctin Ave., Frederick, MD 21701 other 20a. Method of Disposition

1XXBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Deportment of Important: If any injury or once. injury or Mount Olivet Cemetery Sept. 14, 2004 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 East Church St, Frederick, Maryland 21701 21. Signature of Funeral Service Licensee ichen M00255 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Res piratory **Physician** /Medical Due to (or as a ronsequence of). Examiner Sequentially list conditions, any, leading to infine distinctions. Enter Underlying Cause (Disease or injury that initiated events Examiner be executed the burial-transit Colon Cource resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) the a detached 9☐ Unknown 9 Unknown signed by t d be detach Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2XNo 1 ☐ Yes 2 No 1 Yes Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifica funeral director. 25. Was case referred to medical Be 26. Place of Death Check onl one axaminar? Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 mg D41866 Sept 9, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kanan Hudhud, M.D., 46-B Thomas Johnson Drive, Frederick, Maryland 21702-4300 31. Date filed (Month, Day, Year) 32. Regis ar's Signature State Registrar

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	0		Decedent's Name (First, Middle, Last)				2. Date of Death	E-0-04-	3. Time of Death
п	Physici:		Joann Flizabeth	Frith			Month D	ay Year <b>7</b> 200 9	1 1 PM
×	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		c. County of Death	
			Holy Cross Hospital		Silver s	Spring	mp	montgo	nery
	Funeral		5. Social Security Number 6. Sex 7. Age (I	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year	9. Birth	place (State or Foreign
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	and •		Usual Residence of Decedent  10a. State 10b. County 1	0c. City, Town or Lo	ncation				10d. Inside City Limits
	Aaryli f sho	ō		4.1	4	MD			17⊠Yes 2 □ No
	28a-	rect	10e. Street and Number	21/461 38	10f. Zip Code	<u> </u>	10a C	itizen of What Cou	/ `
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	death	Funeral Director	11 Marital Status unit 12. Was Decedent Eve	er in U.S. 13.1	Was Decedent of His		cify Yes or No-	14. Race - Amer	ican Indian.
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21215-0036	within 72 hours after death with the Maryland ene. then "neturel; or Items 23e or 28a-f show the Madical Examitter court be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupat		16b.	Kind of Business/I	ndustry
2	nithin ne. hen	ηp	Elementary/Secondary (0-12) College (1-4or 5+)	/ife. L	DO NOT use retired)	and most of moral	<i>'</i> 9		
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ž	should band Ment and Ment marked	ဥ	Charles Pryor Jr  19a. Informant's Name/Relationship (Type, Print)	106 14-16-			Elizabeth		
Maryland			Holy Cross Hospital				l Route Number, City d Silver S		
ē,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is eny injury or other tra			20b. Place of Dispo	sition (Name of	. D		ocation - City or T	
altimore,	ages ent of nt: If i		1 Burial 2 Cremation 3 Removal from State	cemetery, cren	natory or other place,	)		,	
≣	artim orter injur		21. Signature Fineral S. Dec Licensee Rolland S. Wade Direc	- 22	2. Name and Address	of Facility	(FF II De	1	3.4.
m	Depa Impo eny ir		wade the		ate Anato iltimore,	my воаго MD 21201	655 W. Ba	Itimore :	street
			23a. Part1. Enter the disease, of complications that caused the shock, or heart failure. List only one cause on each line.				r respiratory arrest,		Approximate
E	Pnysician :		Immediate Cause (Final	vsis					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as a condition at a conditio	onsequence of):					1 week
В	Examiner		Sequentially list conditions, b.	enal	Failure	2			1 month
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87	physic the t	dicai	d.						
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Вох	that the death cer ed by the attendir detached for use	clan	in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	Day Year
o.	the d by the ached	ysi	1 Yes No 4 Pregnant at time 9 Unknown						
<b>a</b> .	The law requires that the death certificate has been signed by the attending lage? should be detached for use as	by PI	Part II. Other significant conditions contributing to death but n	ot resulting in the ur	nderlying cause given	in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
Vital Records,	w requires been signe should be	q pa	Jaundice.				1 ☐ Yes 2	XNo 3□Prol	bably 4 Dunknown
၀	law requasis been 2 should	piet	Thrombo cytopenia				24a. Was an	24b. Were auto	opsy findings available
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a	ysician: The is certificate his director, page	Bec	25. Was case referred to medical			26. Place of Death		1 103	2010
<u>~</u>	Attending Physician: If death. ector: After this certifics by the funeral director,	To	examiner?  1 Tes 2 No Hospital: Impatient	2 ER/Outpatient	t 3 DOA Other	4 ☐ Nursing Hom	ne 5 🗆 Residence	6 ☐Other (Special	(y)
Division of	ng Pi	on:	27. Manner of Death  → Natural 5 □ Pending  28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injury a Work?	at 2	8d. Describe how inju	ry occurred	
<u>sio</u>	Mtendi death. ctor: A y the fu	cati	2 Accident investigation		M 1 □ Ye	s 2 🗆 No			
$\leq$	after d Direct Direct	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (3	At home, farm, stre Specify)	eet, factory, office	2	8f. Location (Street at City or Town, State	nd Number or Rura 9)	al Route Number,
	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the funer		200 Contition Secretarion Physician Technology			<u> </u>			
	a Hospite 24 hours a Funerel etely filled	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of m 2 Medical Exeminer: On the basis of example and manner stated	amination and/or inv	occurred at the time restigation, in my opir	, date and place, as nion, death occurre	nd due to the cause(s d at the time, date an	) and manner as s d place, and due to	tated. the cause(s)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier		29c. License r	number	29d. Da	te signed (Month,	Day, Year)
)	F>F0		Plate B. Slever mp		0 21	910			
			36 Name and address of person who completed cause of death	1 (Item 23a) (Type. I	Print)	110	- 7	, ,	D 20906
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9, 2004 September LLOYD LEON GAITHER 0311 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
JAN. 20, 1941 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1√2 M 2 □ F Hours Months | MARYLAN D 215 36 8365 63 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Items 23e or 28e-f show the Medical Examiner must be notified at BALTIMOR E Director 1 Yes 2 No MD. N/A 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 5511 BOWLEYS LANE 21206 U.S. OF A. death Funeral 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. X☐ Never Married 2☐ Married filed within 72 hours after 1 Yes 27 No If Yes, Give Year or Dates: Specify: BLACK Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH UNKNOWN HANDYMAN RACE TRACK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fi Health and Mental H tam 27 is markad ot **EVAN** GAITHER VIRGINIA GAITHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If itam 27 is
any injury or other trau CATHERINE L. JENKINS (SISTER) 6012 THE ALAMEDA BALTO., MD. 21239 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State MT. ZION CEMETERY 9/14/04 LANSDOWNE, MARYLAND ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of guaral Service Livers **E**WYNN LEWIS AT SUNT FUNERAL HOME wenn 4517 PARK HEIGHTS AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each like. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCUEROTIC CARDIOMSCUMAR DISEASE /Medical Due to (or as a consequence of) **Examiner** f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed ician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 MELLINS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Nnknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 → Yes 2 □ No has page 2 certificate Division of Vital 1 Yes 2 No the Hospitel or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1XYes 2 No 2 1 Inpatient 2 TER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 3 
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 9, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 RUBIO, MD ANA 31. Date filed (Month, Day, Year) SFP 13 2004 32. Registrar's Signature State Registrar

Remains not recovered Court order issued by Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Judge Kathleen Cox State of Maryland / Department of Health and Mental Hygiene Case #T-99-046 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Da Physician Thomas Jackson Gibson III July 15, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1₩ 2□F Months Hours Min 57 516-58-9703 Yrs Director May 4, 1947 Washington DC Usual Residence of Decedent death with the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturs!, or Itams 23a or 28a-f shorthe Woolcal Examinar must be notified at Parkville MD Baltimore 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 1713 Edgewood Road Apt. B 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Pagas 1 and 2 should be filad within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "naturst", or Ita rry or other traumatic svent, The Modical Exemptor 1 ☐ Yes 2 🔁 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Laureen Hickok Thomas Jackson Gibson Jr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
234 Silver Brooke Circle, Pooler GA 31322 Theodore W. Gibson Sr. Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State tant: \* 4 ☐ Donation 5 ☐ Other (Specify) permit.
Departn
Imports
any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Undetermined /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law raquires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached Ö 9 Unknown 9 🗀 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records. be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy certificate 1 Yes 20 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Stother (Specify) Court order 1x Yes 2 🗌 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide

in by the funeral director, Division or Attsnding s after death. I Diractor: A To the Hospital within 24 hours a To the Funaral I filled

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician to the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner 29d. Date signed (Month, Day, Year)
Court ordered 29b. Signature and title of certifier 29c. License number OCME July 15, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 David Fowler, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature Species

Medical

State

SEP 1 3 2004

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 55 P M estember 2000 Michael C. Garrison, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris at Mercy Hospital Baltimore 5 4 1 N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
July 22, 1956 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**⊠**M 2□F ountry) Texas 214 66 3682 48 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic evant, the Medical Examiner must be notified at Anne Arundel Baltimore 1 Yes 2X No Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Items 23a or 5519 Wasena Avenue 21225 U.S. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 No If Yes, Give 1 Never Married 20 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2K No Specify: Š 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 3 years Supervisor F.M.C. Corp. 17. Father's Name (First. Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Beatrice A. Parks Billy Twain Garrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other trai once. 5519 Wasena Avenue Shirley Garrison / wife Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State '4 □Donation 5 NOther (Specify) Entombment Cedar Hill Cemetery 9/13/2004 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee > 4001 Ritchie Highway Baltimore, Maryland 21225 massuraciffer 23a. J. 11. Enter the disease, of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. Lo only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final bladde **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physician Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) P.O. I ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 1 ☐ Yes 2 ☐ No 4 Dnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificate has 2 1 No 1 TYes Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6. Other (Specify) haspice 1 🗌 Yes 2 No 2 ER/Outpatient Certification: To 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Tyes 2 No death. 2 Accident investigation the Diractor: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide within 24 hours a To the Funaral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 9/10/2004 ~ 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) md. 301 ST 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 3 2004 love & Sparle Registrar

GARRISON,

	For State Registrar		Otato o	i iviai yiai i		tificate o		Mental Hy			
	Hegistrar     Decedent's Name	/First Middle Last)			00,	incate of	Death	2. Date of Dea	Reg. No.	AL.	12-20-7
Physician /Medical		Mae Guida				_		Septemb	Day	004	3. Time of Death 3:15 PM
Examiner	4a. Facility Name (If	not institution, give	street and nun	nber)		4b. City, Town	or Location of Dea	th	4c. County	of Death	
	Avalon	Manor Nu	rsing l	lome			erstown		Wash	ingt	on
Funeral Director	5. Social Security Nu 180-28-79	1 1	M 2∏7 F	7. Age (In yrs. I. 69	ast birthday) Yrs.	If Under 1 Yea Months Day			1935	Cour	place (State or Forei ntry) nsylvania
NOW I	Usual Residence of I	Decedent 10b. County		10c. City	, Town or Lo	cation				1	10d. Inside City Limi
Ba-fal		Washingto	n	I I	lagers			• • • • • • • • • • • • • • • • • • • •			1 ☐ Yes 21⁄2 N
B or 2	10e. Street and Num					10f. Zip Code	017/0		10g. Citizen of		ntry?
s 23	14014 Ma		10 Mas Dass	dent Ever in U.S	2 140	M = D = 1 = 1 = 1	21740	2 - 1/2 / 1/2	USA		can Indian.
if Health and Menial Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f ahow other traumatic event, the Medical Erac' if ar maral ke inclined at other traumatic event, the Medical Erac' if ar maral ke inclined at other traumatic event, the Medical Erac' if ar maral ke inclined at the Completed by Funeral Director	11. Marital Status 1 Never Marrie 3 Widowed 4	d 2 Married	Armed For 1 Yes If Yes, Giv Year or Da	rces?	1	was Decement of fYes, specify Cu I□Yes 21X N	Hispanic Origin? (s ban, Mexican, Puer D Specify:	to Rican, etc.)	Specif	ck, White,	
Vigine.  19 The Medical Error is at must be redified at it, the Medical Error is at must be redified at Completed by Funeral Director	(Specif	15. Decedent's Edu y only highest grade	cation		(Give	dent's Usual Occ kind of work don	e during most of wa	orking	16b. Kind of B	usiness/In	dustry unk
To Be Compie	Elementary/Secon	dary (0-12)	College (1	-4or 5+)	me.	oo NOT use reti sales	clerk				
d othe event,	17. Father's Name (F							me (First, Middle,		1e)	
I Men natic	Ja: 19a. Informant's Nar	mes Malat			10h M-10-	- A 1 1 /C		n Laminar		a. =:	
aalth an n 27 Is r ier traur	Barbara R			er			at and Number or R Street ]			2174	_ ′
nent oner; if		osition ]Cremation 3 □R 5 MOther (Specify)		State	ace of Dispo metery, crer	sition (Name of natory or other p	ace)	Date	20c. Location -	City or To	own, State
Departn Importa any inju	21. Sign ture of aun	eral Service License	ade, D	irector	St Ba	Name and Add ate Ana ltimore	ress of Facility LOMY Boar MD 212	d 655 W. 01	Baltim	ore S	treet
	shock, or heart	e disease, or compli failure. List only or	cations that can be cause on e	aused the death	. Do not ent			c or respiratory arr	est,		Approximate Interval Between Onset and Death
hysician /Medical	Immediate Cause (F disease or condition resulting in death)	-inal a	1,		webl	Pier					1.242
xaminer			Cha	or as a consequ	ence or):	cho 1	outness,	an	and the same of th		<b>3</b> -,
je je	Sequentially list condif any, leading to immocause. Enter Undert Cause (Disease or in	ditions, nediate lying	Due to (	or as a consequ	ence of):						
ysician and le burial-transit cal Examiner	that initiated events resulting in death) La		. Due to (	or as a consequ	ence of);						
physician the buria			l							_	
this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit.  To Be Completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	1 Live b	come of pregnar irth 2 Fetal ant at time of de wwn	death 3 □	Ectopic pregnan Other (specify)	су		23d. Da Mo	e of delive	ery Day Year
i signed by the a Id be detached f d by Physic	Part II. Dther signific		_		•	, ,	iven in Part I.	23e. Did to	bacco use cont	ribute to th	ne cause of death?
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cate has been s page 2 should								24a. Was a autops perform	ned?	Vere autoprior to condeath?	psy findings available appletion of cause of
certificate rector, pag	25. Was case referre	ed to medical					26. Place of De	ath (Check only on			
this cert al direct	examiner?	16 H	lospital: 1 □ li	npatient 2 🗆 E	R/Outpatien	t 3□ DOA C	ther: 4 Nursing H	lome 5 ☐ Reside	ence 6 Oth	er (Specify	′)
ath. r: After this certific le funeral director, ation; To Be	27. Manner of Death 1 ☑Natural 2 ☐ Accident	5 Pending investigation	28a. Date of	f Injury h, Day Year)	28b. Time of Injury			28d. Describe ho			
within 24 hours after death. To the Funeral Director: After t completely filled in by the funera  Medical Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place buildir	of Injury - At hor ng, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Numb n, State)	er or Rura	l Route Number,
within 24 hours after deal To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only 2 one)	Certifying Phys	sician: To the ner: On the ba and mann	sis of examinati	riedge, death on and/or inv	occurred at the restigation, in my	time, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and ma ate and place,	nner as st and due to	ated. the cause(s)
To the comp	29b. Signature and ti	itle of certifier	~0				Se number		9d. Date signed	•	
	30. Name and address	ss of person who co	mpleted caus	e of death (Item	23a) (Type,	Print)	HASS	05-01	v 1-	D 2	121-
	31. Date filed (Month	DART DART DAY, Year) SEP 13 20	32. P	histrar's Signat	ire (			~>~~~		0 4	11/40
State		1.0.00		in a signat	4						

			For State Registrar	State of Man		artment of H			giene		28970
	Physici	an	1. Decedent's Name (First, Middle, Last)			_		2. Date of Dea	Day	Year	3. Time of Death
	/Medic	al	Robert Jose  4a. Facility Name (If not institution, give s		amilton,		Location of Death	Sept 4		nty of Death	10:12AM <sup>M</sup>
	Examin	er	Sacred Hea		1		berland		Alle	•	
	Funeral		5. Social Security Number 6. Sex	7. Age (II	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da			lace (State or Foreign
ı.	Director		233-36-3270	M 2□F	67 Yrs.	WOTHIS Days	Tiodis IVIII.	July 18	3,1937		Virginia
	land ow		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Lo	cation				1	0d. Inside City Limits
	Mary a-f sh	tor	WV Mineral		Keys	er					1 XYes 2 □ No
	th the or 284 e not	Funerai Director	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·		10f. Zip Code			10g. Citizen o	of What Cour	ntry?
	eth w	rai	38 North "F" Str			267				USA	
	er der Items	une		<ol> <li>Was Decedent Eve Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No</li> </ol>	r in U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. R	ace - Americ lack, White,	
2	urs aff	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Spec	cify: Wh	ite
2-003e	72 ho natura	eted	15. Decedent's Educ (Specify only highest grade		16a. Deced	dent's Usual Occupa kind of work done of	ation during most of work	ina	16b. Kind of	Business/In	dustry
7	vithin ne. hen "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired,	)	9	D	W-271	
7	Hygie thert	e Co	12 17. Father's Name (First, Middle, Last)		Mi	llwright	18. Mother's Name	e (First, Middle,	Paper	-	
yland	ld be ental ked o	To Be	Albert Hamilton					ie Bell		,	
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Type	oe, Print)		ng Address (Street a	and Number or Rura	al Route Numbe	r, City or Tow	1.3	Code)
, Mai	and 2 ealth a n 27 i		Eula J. Hamilton/			North "F"				6726	
ore	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28a-f show amy injury or other treumatic event, The Madical Examiner must be notified at ance.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	-	natory or other place	<sup>θ)</sup> ¦ Se	ept. 9	20c. Location	n - City or To	wn, State
gaitimor	it. Pa rtmen rtent: njury		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>		otomac Me	emorial G			Keyse	-	
o O	Depa Impo		Buint 1	W/L		B5 S. Mai:		Smith F Keyse	er, WV	. поше 2672	26
г			23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	cations that caused the							Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition	Cardiom	vonathy						Onset and Death Uk yrs
	/Medical Examiner		resulting in death)	Due to (or as a co							010 / 10
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ה ה	be executed ician and burial-transit	Еха	that initiated events c resulting in death) Last	Due to (or as a co	onsequence of):						
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ō	leath certificate attending phys I for use as the	hysician/Med	IF FEMALE:	3c. If yes, outcome of p							
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cords	w require been sig should t							101	es PNo	3 Prob	ably 4 Unknown
ပ္သ	law as b	ompieted						24a. Was autop	sy	prior to co death?	psy findings available mpletion of cause of
<u> </u>	Th ate pag	O							2 No		2 No
VII		o Be	25. Was case referred to medical examiner?  1 ★ Yes 2 □ No	ospital:	2 ER/Outpatier	othe Othe	26. Place of Deatler: 4 Nursing Ho			Athas (Casail	
Ö	g Phys er this eral di	H-	27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time of			28d. Describe h			7)
IVISION	Attending Ir death. sctor: After by the funer	atio	Natural 5 Pending investigation	(Month, Bay 1	oar) Injury		Yes 2 □ No				
Ĕ	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (		eet, factory, office		28f. Location (S City or Tow		nber or Rura	l Route Number,
_	urs a	i Ce	29a. Certifier 1 ☐ Certifying Phys	icien: To the best of n	ny knowledge deat	a occurred at the time	ne date and niane	and due to the	causa(s) and	manner as s	ated
	To the Hos within 24 ho To the Func completely f	edicai	(Check only one) 2 Medicel Exemination	ner: On the basis of ex and manner stated	amination and/or in	vestigation, in my or	pinion, death occur	red at the time,	date and place	e, and due to	the cause(s)
1	To the within 2 To the comple	Me	29b. Signature and little of certifies			29c. License D0915			29d. Date sign	ned (Month, t 4 20	
			1/0/1//	~		D031_				- + 40	· · ·
	4		30. Name and address of person who co								
	Sta	ite.	Paul Snow, M.D. 31. Date filed (Month, Day, Year)	Dpty Mrf 32. Resistrar's	Ex 124 W Signature	3rd St Cu	ımberland	, MD 21	1502		
	Regist		SEP 1 3 20	32. Redistrar's	N A A	porte					

			1 - For State Registrar	State of Ma	-	epartment o Certificate		nd Mental Hyg	iene 9g. No. () () (	28879
	Physici	an	Decedent's Name (First, Middle, Las	•				2. Date of Deat Month	Day Ye	
	/Media	al	Beverly Ar			4h Cihi Toi	wn, or Location of [	SEPTEMBE	4c. County of D	1 100 100 1
4	Examir	ier	4a. Facility Name (If not institution, give	Medical	Center	40. Oky, 10	Afficial Afficial	wson	-	altimore
	Funeral Director		212-36-043/	9x 7. Ag □ M 2	e (In yrs. last birtho 66 Yrs	Months D		Hrs. 8. Date of Birth (Month, Day, Aug. 17	, 1938 9.	Birthplace (State or Foreign Country) Maryland
	ow ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	a-feh	tor	Maryland Carr	coll		Ţ	Westminst	er		1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number	. 1		10f. Zip Co		1	0g. Citizen of What	*
	s 23a	erai	424 Union Town F	12. Was Decedent	Ever in 11 C	12 Was Dasadas	21158	2 /Specific Vector No.		States
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f ehow appring yor other traumatic event, the Medical Evant and the hydied at annotice.	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 🛣 Divorced	Armed Forces?  1 Tyes 2 Xi  If Yes, Give  Year or Dates:	10 No	If Yes, specify		n? (Specify Yes or No- Puerto Rican, etc.)		white, etc. White
2-0	72 ho 'natur	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. De	ecedent's Usual C	occupation done during most of retired)	f working	16b. Kind of Busine	ess/Industry
21215-0036	giene. er than '	Compl	Elementary/Secondary (0-12)	College (1-4or 5	+)	Homema			Own H	Iome
Maryland	2 should be filed within 72 hours aft and Mental Hygiene. Is marked other than "natural, or aumatic event, the Medical Exercia	To Be (	17. Father's Name (First, Middle, Last)  Joseph	Earl R	odert			Name (First, Middle, M Nuth	faiden Sumame) Lynch	1
Mary	nd 2 shou Ith and N 27 Is mai		19a. Informant's Name/Relationship (7 Charles Hill / So					or Rural Route Number, house Rd.,		e, Zip Code) ster,MD 21158
Baltimore,	ages 1 and 3 nt of Health :: If Item 27		20a. Method of Disposition  1  Burial 2 Cremation 3		20b. Place of Di cemetery,	sposition (Name crematory or othe	of r place) Se	ept. 13	20c. Location - City	or Town, State
Itin	permit. Pag Department Important: any injury conce.		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licentary</li> </ul>	)	-	ake Crem	ddrose of Eacility		Beltsv	
B	permit. Departr Imports any inje		> Stralu A Ko	Remain	M00382	CAFA Ste	ephen D.	Lohrmann P res Dr., Ba	.A. altimore	MD 21286
100	Physician	2 1	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each lir	the death. Do not ne.	enter the mode o	f dying, such as ca	rdiac or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):			4		DHYS
	LAdillilei	10	Sequentially list conditions,	b	RY ARTE	KA DIDE	HöL			YEARS
	uted d ansit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		, , , , , ,					
oʻ	ate ba executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):	-				
8760,	ate by	dical		d						
Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Med	in the past 12 months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at	2 Fetal death	3 □Ectopic pregr 5 □ Other (specif			23d. Date of Month	delivery Day Year
P.0	hat the od by t detach	Phy	9 ☐ Unknown Y  Part II. Other significant conditions co	ontributing to death b	ut not resulting in th	e underlying caus	e given in Part I	23e. Did tob	acco use contribute	to the cause of death?
ds,	uires thai signed t		Takin and algunation and	minibating to occur by	at not rosalling in the	o underlying caus	is given in runni.	1 □ Ye		Probably 4 Munknown
COL	w requir s been si should	olete						24a. Was ar		autopsy findings available
Vital Records,	The ate h page	Completed						autopsy perform	prior death	
Vita	Physicien: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner?	Hospital:	4.5500		Othor	Death (Check only one		
of	ding Phys th. : After this funeral di	tion: To	1 Yes 2 No  27. Manner of eath 1 Natural 5 Pending 2 Accident investigation	1 X Inpatie 28a. Date of Injui (Month, Day	y 28b. Tim	e of 28c.	Injury at Work?  1 Yes 2 No	ng Home 5 🗍 Reside 28d. Describe ho		pecify)
Division	To the Hospitet or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, farm, c. (Specify)	street, factory, of	fice	28f. Location (Str City or Town		Rural Route Number,
	e Hospite 24 hours e Funerel etely filler	Medical C	29a. Certifier (Check only one) 1 Certifying Phy	rsician: To the best of iner: On the basis of and manner sta	examination and/o	eath occurred at to r investigation, in	he time, date and p my opinion, death	place, and due to the ca occurred at the time, da	use(s) and manner te and place, and c	as stated. due to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	1	λ	29c. Li	cense number	(29	d. Date signed (Mo	onth, Day, Year)
	1		) H.J. H	elou, M	.5	D	17695	2	eptember	10,2004
	b		30. Name and address of person who c		eath (Item 23a) (Ty	pe, Print)				
	Sta		ABDALLAH J. HEL  31. Date filed (Month, Day, Year)	32. Registra	7601 ur's Signature	OSLER I	DRIVE TO	OWSON, MA	RYLAND :	1204
	Registr	_	SEP 132	2004	m &	Gode				

	1				ryland / Depa <b>8a-f peg i</b>	lificate of	Death			22220
Physiciar		1. Decedent's Name (First, Middle						2. Date of Dear	5,2004 Year	3. Time of Death
/Medica	1	Christine Jone  La. Facility Name (If not institution		umbar)		4b. City, Town, o	Logation of Don			
Examine	r	1820 SPENCE SI					ORE CITY		4c. County of De	am
Funeral Director		5. Social Security Number 220-42-5274	6. Sex 1 ☐ M 2 【 F	7. Age	(In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 9. B 1944 MD	irthplace (State or Fore Country) )
and *	-	Usual Residence of Decedent  10a. State 10b. County			10c. City, Town or Lo	cation				10d. Inside City Lim
ith the Marylar or 28a-1 show	5	MD			Baltimore					14 Yes 2□
the rott	Director	10e. Sireet and Number		1		10f. Zip Code		1	0g. Citizen of What (	Country?
23a o	= =	1820 Spence Str	eet			21202			United Sta	ates
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show minoriant: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any jury or other traumatic event, the Medical Examiner must be notified at 2008.  To Be Commissed by Europe Discours	2	11. Marital Status  1 Never Married 2 Marri	12. Was Dec Armed F 1 ☐ Yes If Yes, G	orces?		Was Decedent of H f Yes, specify Cuba	ispanic Origin? ( in, Mexican, Puel Specify:	Specify Yes or No- no Rican, etc.)	14. Race - Arr Black, Wh	nerican Indian, nite, etc.
ural',	ya by	3 ☐ Widowed 4 ☑ Divorced	Year or t						Whi	
within 72 ene. than "nat ne Modic	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	's Education it grade completed, College		(Give	lent's Usual Occup kind of work done o DO NOT use retired	durina most of wa	orkina	16b. Kind of Busines Unknown	s/Industry
Hygi ent.	ပ် မ	17. Father's Name (First, Middle, I	Last)				18. Mother's Na	me (First, Middle, I	Maiden Sumame)	
Mental Mental Med v	0 26	Nelson Eichelb	erger Jor	nes			Ruth Ir	ene Cunni	ngham	
shot s mar umat		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailie	g Address (Street	and Number or A	lura <i>i Route Number</i>	. City or Town, State,	Zip Code)
and 2 alth a 27 k		Terah Cochrans	/Niece		608 1	lorningsi	de Drive	, Southla	ake, TX 76	092
Pages 1 and of He out: If Item Ity or other	1	20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 1 ☐ Donation 5 ☐ Other (Sp		n State	-	sition <i>(Name of</i> natory or other place ke Cremat		Sep 10	20c. Location - City o Beltsville	
permit. Departrimonts Imports any inju		21. Signature of Funeral Service	densye Jamann		22	. Name and Addres	s of Facility and Fur		ernatives Baltimor	co MD
ificate be executed by physician and minal state burial-Iransit and and and and and and and and and and	Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a	consequence of):  consequence of):  consequence of):					
Attending Physician: The law requires that the death certific ar death.  In death.  In death.  In the first this certificate has been signed by the attending perter. After this certificate has been signed by the detached for use as by the funeral director, page 2 should be detached for use as fit after Transfer and Marking the Completed by Physician Marking.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		birth 2 nant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
tw requires that is been signed to should be det		Part II. Other significant conditio	ns contributing to o	death but	not resulting in the u	nderlying cause give	en in Part I.			to the cause of death? Probably 4 Unkno
ystotan: The law requires is certificete has been significate has been significator, page 2 should be Commisted.	Comple							24a. Was ar autops perform 1 \( \text{Yes} \) 2	v prior to	autopsy findings availa completion of cause s 2 \sum No
certificate rector, pag		25. Was case referred to medical examiner?	Hospital:			045		ath (Check only on		
ding Physi h. After this c funeral dir		YXYes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investig	28a. Date	of Injury	t 2 ER/Outpatier  28b. Time of Injury	28c. Injun Work	4   Nursing r	28d. Describe ho		ecify) AT SCE
2 4 4 C	, er mica	2 Accident 3 Suicide 4 Homicide	not be 28e. Plac	dina, etc.	y - At home, farm, str (Specify)		Α	28f. Location (Str City or Town Baltimor	eet and 1820 or S	pence St.
To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I		29a. Certifier 1 Certifying 2 Medical E	<b>Examiner</b> : On the b	e best of basis of e	my knowledge, death examination and/or in- ed.	occurred at the time restigation, in my op	e, date and place pinion, death occi	e, and due to the ca	use(s) and manner a	is stated. e to the cause(s)
To the within 2 To the comple		29b. Signature and fittle of cegifier	am				·M.E	29	SEPT. 6,	
		30. Name and address of person	who completed cau	Se of Se	ath (Item 23a) (Type,		Baltimo	ore. Marv	land 21201	
State		31. Date filed (Month, Day, Year)	16	Registrar	's Signature	•		7	21201	

			1 - For State Registrer			/ Dep		lealth an	d Mental Hy			28881
	Dhuciei	-	1. Decedent's Name (First, Middle, La	st)	-	,			2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medio		William	hurman	Jac	K20	7		Month	4	04	6:45 PMM
	Examir		4a. Facility Name (If not institution, giv		1 -	,	4b. City, Town, o	r Location of C	eath	4c. (	County of Dea	th
			Baltimore VA	Medical		_	Balti					
	Funeral Director		010-22-5871	M 2 F	e (In yrs. las	t birthday Yrs.	Months Days	Hours	Hrs. 8. Date of Birt Min. (Month, Da	h y, year) 26	N. Co	thplace (State or Foreign ountry) ryland
	and w		Usuel Residence of Decedent  10a. State 10b. County		10c. City,	Town or I	Location					10d. Inside City Limits
	Mary f she	ō	MD			Ba1	timore					1 Yes 2 No
	28e	rec	10e. Street and Number			-	10f. Zip Code			10g. Citiz	en of What Co	ountry?
	3a or	<u></u>	1100 Pennsylvani	a Avenue i	<i>‡</i> 1308			21201			USA	
	ms 2	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13			? (Specify Yes or No- uerto Rican, etc.)	- 1	4. Race - Ame	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28e-f show the Mydical Examiner must be multified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	Armed Forces?  1 X Yes 2 □ N  If Yes, Give  Year or Dates:	 50-5		If Yes, specify Cubin	an, Mexican, P Specify:	uerto Rican, etc.)		Black, White Specify: b	
Ŏ	2 ho	ted	15. Decedent's E	ducation		16a. Dec	edent's Usual Occup	ation		16b. Kin	d of Business	/Industry
215	thin 7	pld.	(Specify only highest gra	College (1-4or 5	5+)	life.	re kind of work done DO NOT use retire	d) auring most of	working			
	filed with Hygiene other thai	00	6	Ŏ			bartender	<u> </u>		pac	kage g	oods
p	al Hy	Be	17. Father's Name (First, Middle, Last,						Name (First, Middle,		Sumame)	
Vla	should be and Mental s marked o umatic eve	၉	William T. Ja	ckson				A	gnes Thoma	ıs		
Maryland	and 2 sho ealth and n 27 is mu		19a. Informant's Name/Relationship ( Lauren Muhammad						r Rural Route Numbe enue Balti			Zip Code) 21207
Baltimore,	- I 0 =		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☒ Donation 5 ☐ Other (Specif		com	ce of Disp netery, cr	position (Name of ematory or other place	ce)	Date	20c. Loc	ation - City or	Town, State
Baltii	permit. Pages Department of I Important: If Its any Injury or o		21. Signatura of Euneral Service Licer ROTIALD S.		ector	auto-		THE RESERVE OF LABOR.	ard 655 W.	Bal	timore	Street
			23a. Par 1. Enter the disease, or com	plications that caused	d the death.		Saltimore, nter the mode of dvir		L201 diac or respiratory ar	rest.		Approximate
	Physician /Medical Examiner		sho k, or heart failure. List only Immediatly Cause (Final disease or condition resulting in death)	a. Due to (or as	card	nce of):	Infa.	redion				Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a conseque	nCeruit):						<u>.</u>
8760,	eath certificate be executed attending physicien and for use as the burial-transit	ca	resulting in death) Last	Due to (or as	a conseque	nce of):						
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3	:□Ectopic pregnanc; □ Other (specify) _	1		2	3d. Date of de Month	livery Day Year
Records, P	quires that n signed l	by	Part II. Other significant conditions of	•		-	underlying cause giv		23e. Did to			o the cause of death?
S	w requir been si should	Completed	H. a. lassin						24a. Was	an	24b. Were at	utopsy findings available
Re	The lav	щ	11900 7015101	1 1						rmed?	death?	completion of cause of
		a	25. Was case referred to medical	try Dis	schol .			26 Place of	1 ☐ Yes  Death (Check only of		1 □ Yes	2 1 No
>	Physician: this certificanal director.	To B	examiner?	Hospital:	ent 2 EF	3/Outnate	ent 3 DOA Oth	000	ng Home 5 Resid		Other (See	mifu)
	ar this		27. Manner of Death	28a. Date of Inju	iry 2	8b. Time	of 28c. Injur	y at	28d. Describe h			eny)
on	nding Ph th. : After th s funeral	it lo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigatio	( <i>Month, Da</i> j	y Year)	Injury		k? Yes 2∐No				
Division	l or Attanding after death. Director: After in by the funer	Certification;	3 Suicide 6 Could not be determined	286. Place of Inj	ury - At hom c. (Specify)	e, farm, s	street, factory, office		28f. Location (S City or Tow		Number or Ri	ural Route Number,
_	To the Hospitel or Attano within 24 hours after death To the Funerel Director: completely filled in by the t	edical C	29a. Certifier (Check only one) 1 Gertifying Pt	nysicien: To the best miner: On the basis of and manner sta	f examination	edge, dea	ath occurred at the tir investigation, in my c	me, date and p prinion, death o	lace, and due to the o occurred at the time, o	cause(s) a date and p	and manner as place, and due	s stated. a to the cause(s)
	o the	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date	signed (Mont	h, Day, Year)
	P 5 F Ö		1/(	2"	17		Po	158	81	91	4/04	
			30. Name and address of person who	completed cause of a	leath (Item ?	3a) (Tye		130	~ [		1101	
			1 1	AD . IQ N	G = -	- (1	Balh-	ore MI	D 21201.			
	Sta	ite	31. Date filed (More) Op, Year 7	104 32 3 egistr	ar's Signatu	9	bede Balton	1	3,201.			
	Regist	- 24	021 - 021	The state of the s	0	19	perke					

			_ State		artment of Health and N rtificate of Death	, ,	2000 20000
ſ	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month D	3 Time of Death
	/Medic Examir	cal .	Howard Ne  4a. Facility Name (If not institution, give street an	wton Koerr	1er 4b. City, Town, or Location of Death	September 4	11,2004 6:05 P M
24		p.	6326 Hazelwood Avenue		Rosedale		Baltimore
ĺ.	Funeral Director		5. Social Security Number 6. Sex 1. M 2.	7. Age (In yrs. last birthday) F 78 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Aug, 17, 19	r) 9. Birthplace (State or Foreign Country) Maryland
	yland Tow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Le	ocation		10d. Inside City Limits
	the Mar 28a-f sl	Director	Maryland Baltimore  10e. Street and Number	Rosedale	10f. Zip Code	100.0	1 Yes 2 No
	th with 23s or		6326 Hazelwood Avenue		21237	Tog. c	USA
920	within 72 hours atter death with the Maryland ene. than "natural", or items 23c or 28a-f show the Madical Examinitation that be inclifted at	by Funeral	1 Never Married 2 Married 1 Ye	'es 2 □ No	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes    Yes   No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	1 within 72 ho piene. r than "natur the Medical.	Completed	15. Decedent's Education (Specify only highest grade comple	ted) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/Industry
212		Comp	12	ge (1-4or 5+)	Clectrician		onstruction
land	be de la la la la la la la la la la la la la	To Be	17. Father's Name (First, Middle, Last)  Valentine Koe	rner	18. Mother's Name	e (First, Middle, Maide NCE Was	on Sumame) stler
Mary	2 sho and is m		19a. Informant's Name/Relationship (Type, Print Kathy Koerner Emerson		Micromico Street		
			20a. Method of Disposition  1 \(\overline{\text{Z}}\)Burial 2 □ Cremation 3 □ Removal	20b. Place of Dispo			Location - City or Town, State
Baltimore,	Pa ant:		'4 □ Donation 5 □ Other (Specify)  21. Ignature of Funeral Service Lice see	Gardens c	of Faith Cem. 9/15/		timore, Maryland i Funeral Home PA
Ba	permit. Departr Imports any inji		A-Bax	1	407 Old EasternAve	enue Essex	
	Physician		23a Pan 1. Enter the disease, or complications t shock, or heart failure. List only one cause Immediate Cause (Final	hat laused the death. Do not ent on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
1	/Medical Examiner		disease or condition resulting in death)	e to (or as a consequence of):	2 (20 x) -1	ζ	
		ner	Sequentially list conditions, if any leading to furn class cause. Enter Underlying Cause, (Disease or injury	e to (or as a consequence of):			
	sician and burial-transit	Examiner	that initiated events C.	e to (or as a consequence of):	E70212		
8760,	cate be ex ohysician the buria	dical	d.				
.O. Box 6	he death certifis the attending p thed for use as	Physician/Med	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Records, P	w requires that to been signed by should be detact	by	Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause given in Part I.		use contribute to the cause of death?
Vital Reco	The law ate has b page 2 sl	e Completed	25. Was case referred to medical			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
of VII	dis di	To Be	examiner?  1 Yes 2 XNo Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpatier	26. Place of Death	me 5 X Residence	6 ☐Other (Specify)
ou o	Attanding Ph r death. actor: Atter th by the funeral		27. Manner of Death  X Natural 5 Pending 2 Accident investigation	Pate of Injury Month, Day Year)  28b. Time o Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how inju	ury occurred
Division	in Sire	Certification;	3 Suicide 6 Could not be determined 28e. F	Place of Injury - At home, farm, struilding, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
	e Hospital 24 hours a Eunaral I	edical	(Check only 2 Medicel Examiner: On t	o the best of my knowledge, death the basis of examination and/or in manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause(sed at the time, date an	s) and manner as stated. nd place, and due to the cause(s)
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier	h Daw w	29c. License number D—Y 8023		ate signed (Month, Day, Year)
	104		30 Name and address of person who completed	daluse of death (Item 23a) (Type,	Print) CHESACS	AVE, B	ACD, MD 21237
1	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 3 2004	Registrar's Signature	nle	· · · · · · · · · · · · · · · · · · ·	

		1 - For State Registrar	State of I	Maryland / [	epartmer Certifica				giene Reg. No.	14 26	1883
Physici		1. Decedent's Name (First, Middle Matthew Mich						2. Date of De Month	. Day	Year 3. T	Time of Death
/Medio		4a. Facility Name (If not institutio	n, give street and numb	er)	4b. City	Town, or Lo	cation of Death	фіст	4c. County	of Death	
	ri <sub>o</sub>	SAINT AGN	IES HEAD	THEARE	15	ALTI	mok	E		N/A	
Funeral Director		5. Social Security Number 216–34–1647	6. Sex 7. 1 □ <b>X</b> M 2 □ F	Age (In yrs. last bir	Yrs. If Under		Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da Sep. 14	th y, Year) <b>1935</b>	9. Birthplace ( Country) Mary1	State or Foreign and
land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. in:	side City Limits
the Marylan r 28a-f show	tor	MD Ba	ltimore		A	butus				1 (	☐Yes 2X No
ith the or 28	Direc	10e. Street and Number			10f. Zi	p Code			10g. Citizen of	What Country?	
s 23e	rai	1103 A Sulphur			10 14/20 Base	2122		anife. Van ar Na		ted Sta	
1215-0036 within 72 hours after death with the Maryland ena. than "naturel", or items 23a or 28a-f show the Madical Examinator must be natified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  3 ☐ Widowed 4 ☐ Divorced	If Yes Give	s? □Nº 1958	If Yes, spi		Mexican, Puerto	ecify Yes or No Rican, etc.)	Bla Specif	ck, White, etc.	,
Battimore, Maryland 21215-0036  Dermit. Pages I and 2 should be filed within 72 hours att Department of Health and Mental Hyginen.  Mportant: If item 27 is marked other than "natural; or may lajury or other traumatic event, the Medical Examplance.	Completed	15. Deceder (Specify only highe	nt's Education st grade completed)		Decedent's Usu (Give kind of w	ork done durir	n ng most of work	ing	16b. Kind of B	usiness/Industry	
121 within ena. than '	idmo	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. DO NOT			٠	A 4	_	
id 2 iffled t Hygin other	Be Co	17. Father's Name (First, Middle,	Last)		Mec	hanic 18	. Mother's Nam	e (First, Middle,	Aut Maiden Sumar		
arylan	To B	Meya Kekich					Margare	et Dolar	1		
Aary 2 sho 1 and 1 1s ma		19a. Informant's Name/Relations			•	in a second				State, Zip Code,	,
ore, Maryland 212: is 1 and 2 should be filed within of Health and Mental Hygiena. item 27 is marked other than other traumatic event, the		Dorothy Kekich 20a. Method of Disposition	Wife	20b. Place of	Disposition (Na	me of		Rd., Ar		MD 2122 City or Town, Si	
Pages nent of int: If it		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5		te Crest	y crematory or Lawn Men		9-1/-	-2004		ttsville	
Battimor. permit. Pages Department of 9 Important: If its any injury or o		21. Signature of Furi-rei Sand	ACCEPTED A	1410	Garde 22. Name a	nd Address o				me, Inc	
<b>a</b> 888 <b>a</b>		Comme	JULIUK	J MUSS	+					MD 2122	27
Prysician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on eac	sed the death. Do r h line. MONAM			,	or respiratory a	rrest,	Inter- Onse	oximate val Between et and Death
/Medical Examiner		resulting in death)		as a consequence	of):	/	son				-
Examiner	5	Sequentially list conditions,	b. Due to for	as a nonsequence		ombo.	50			_	
uted d ansit	Examiner	cause (Disease or injury that initiated events	<b>S</b>								
760, te be executed ysician and		resulting in death) Last	Due to (or	as a consequence	of):						
be at Sylve	dicai		d.							_	
HEW Box 68 leath certificat attending phy	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy	.77				23d Da	te of delivery	
H. MATT HEW I Records, P.O. Box 68 The law requires that the death certifica te has been signed by the attending ph	Physician/Med	in the past 12 months?  1 Yes 2 No 9 Unknown		n 2 🗍 Fetal death t at time of death n	3 □Ectopic p 5 □ Other (s					onth Day	Year
S, P S, that res that igned b	by Pt	Part II. Other significant conditi	ons contributing to deat	h but not resulting ir	the underlying	cause given i	n Part I.	23e. Did to	obacco use con	ribute to the cau	se of death?
ecords, law requires the as been signed 2 should be d	ted	Hyperten	510 n					1 🗆 1	res 2□No	3 Probably	4 Unknown
Vital Reco	Completed								rmed2	Were autopsy fin prior to completic death? 1 □ Yes 2□ N	on of cause of
of Vital of vital Physician:	Be	25. Was case referred to medica examiner?	Hospital:			Othor		h (Check only o			
Phy of a land	): To	Yes 2 No 27. Vanner of Death	28a. Date of (Month,			OA Other: 28c. Injury at Work?	4 Nursing H	ome 5 Resident	dence 6 Oth		
Vision Attending Frideath.	atior	Accident 5 Pendi	ng (Month, igation	Day Year) I	njury M		2 🗆 No				
Divisio Divisio al or Attendi s after death. I Diractor: A	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 200. Place of	Injury · At home, fa , etc. (Specify)	rm, street, facto	y, office		28f. Location (S City or Tov	Street and Numb vn, State)	er or Rural Rout	e Number,
Division  To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	edical (	29a. Certifier (Check only one) 12 Certifyi 2 Medical	ng Physician: To the be Examiner: On the basi and manner	s of examination an	, death occurred d/or investigation	at the time, on, in my opinion	date and place, on, death occur	and due to the red at the time,	cause(s) and madate and place,	anner as stated. and due to the ca	ause(s)
To the within To the comp	M	29b. Signature and title of certific	er (	4.0	1	c. License nu				d (Month, Day, Y	
		MXM	DY.			DOOL	35/		Depter	tu lili	PA
<b>b</b>		30. Name and address of person	Henggelei	of death (Item 23a)	Type, Print)	Avenu	e, Bal	timore	IMO	ta 1.1.	9
Sta Regist	ate rar	31. Date filed (Month, Day, Year SEP 13 20		istrar's Signature	out						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Kilmon, Sr. August September 8, 2004 7:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Heritage Meridian Eldercare Ctr. Baltimore Co. Dundalk If Under 1 Year If Under 24 Hrs. **Funeral** 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1⊠M 2□F Months Days Hours Director 74 Jan. 12,1930 Maryland 216-24-9613 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-1 show other treumatic event, the Madical Examiner must be notified at 1⊠Yes 2 No Director Baltimore City Maryland N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 United States 1043 Hignet Way Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Year or Dates: 1950-56 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. ges 1 and 2 should be filed within t of Heelth and Mental Hygiene. If item 27 Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Warehouseman Lever Brother, Corp. 6 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Franklin R. Kilmon Lillian C. Kapple ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1043 Hignet Way Baltimore, Maryland Mrs. Lilian C. Kilmon / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ment of F 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Importent: If any injury or Gardens of Faith Cem. 9/11/2004 Baltimore, Maryland \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fuda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland Wise Ave. 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-transit Box 68760, attending physician Physician/Medical use as the IF FEMALE: f yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has autopsy 1 Yes 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 ☐ No Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: After 1) Natural 5 Pending investigation death. М 1 🗌 Yes 2 🗆 No Accident after death filled in by the 6 Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BHIVA

DHMH 17 Rev 1/2001

State Registrar 32. Registrar

2004

			1 - For State Registrar	State of Ma	-	artment of rtificate of			jiene	<u> </u>	22225
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Yeer	3. Time of Death
	/Medic	cal	Carol	Lee		Klin		Septemi			5:00 am <sup>™</sup>
	Examir	er 	4a. Facility Name (If not institution, give 122 Kline Blvd			Free	or Location of Deatl derick		Fred	erick	
Ì,	Funeral Director		5. Social Security Number 6. Sec 215-42-4103	7. Age	(In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day Jun 9,	1943	9. Birthpla Countr Mary	ice (State or Foreign Land
	Maryland -f ehow	tor	10a. State 10b. County Maryland Frederi		10c. City, Town or Lo Frede					10	d. Inside City Limits 1   Yes 2  No
	3a or 28e	Funeral Director	10e. Street and Number 122 Kline Blvd			10f. Zip Code	21701	1	0g. Citizen of U.S		y?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural, or Iteme 23e or 28e-f ehow empty fourty or other treumatic event, its Madical Examinar must be neithed at once.		11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	,	Was Decedent of f Yes, specify Cut	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - America ck, White, et y: Whit	tc.
21215-0036	within 72 ho ane. then "netu	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire	pation a during most of wor ad)	king	16b. Kind of B		cations
Maryland 2	should be filed nd Mental Hygie marked other umatic event, III	To Be Co	12 17. Father's Name (First, Middle, Last) John Fin	nory	Baer		18. Mother's Nan Kathry	ne (First, Middle, i			
	and 2 shousalth and Natural Natura Natura Natura Natura Natura Natura Natura N		19a. Informant's Name/Relationship (Ty Kimberly Geiger/C	<sub>Pe, Print)</sub> Franddaugh	ter 19b. Mailir	g Address (Stree Kline I	and Number or Ru Blvd, Free	derick, l	, <i>city or Town,</i> Mary lan	State, Zip C d 217(	Code) 01
Baltimore,	Pages 1 a nent of He ent: If item ury or othe		20a. Method of Disposition  1  Burial 2  Cremation 3  P  4  Donation 5  Other (Specify)	emoval from State	20b. Place of Dispo cemetery, crem Smithsbur	natory or other pla	tory Sep		20c. Location - Smiths		
Balti	permit. Departrimporte eny inju		21. Signature of Funeral Service Ligens				Bastord :				21701
	Physician /Medical Examiner	niner	23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	ne cause on each line  Arterios  Due to (or as a	ne death. Do not ent-	er the mode of dy	ing, such as cardiac	or respiratory arr	est,	1	Approximate nterval Between Onset and Death Cears
92,092,	icate be executed physician and s the burial-transit	ledicai Examiner	that initiated events resulting in death) Last		consequence of):						
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25 No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	sy			te of delivery	ay Year
rds, P.	quires that in signed t	by	Part II. Other significant conditions cor Hypertension	tributing to death but	not resulting in the ur	nderlying cause gi	ven in Part I.				cause of death?
900	e law requir has been s ge 2 should	Completed	Hyperlipidemia					24a. Was a		Were autops	y findings available
Œ		Com	Cerebrovascular D	isease				autops perform	ned?	death?	Diletion of cause of
/ita	ysicien: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?					th (Check only on			
Division of Vital Records,	d S	tion; To	27. Manner of Death 1   Natural  7 Pending	1  Inpatient 28a. Date of Injury (Month, Day)	2 ER/Outpatien 28b. Time of Injury	28c. Inju		ome 5 Reside 28d. Describe ho			
Divisi		Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, farm, stre (Specify)		,	28f. Location (St. City or Town		er or Rural F	Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edicai	29a. Certifier (Check only one) Certifying Physical Exemination (Check only one)	sician: To the best of ner: On the basis of e and manner state	xamination and/or inv	occurred at the trestigation, in my	ime, date and place, opinion, death occur	and due to the carred at the time, da	tuse(s) and ma ate and place,	inner as stat and due to th	ed. ne cause(s)
	To the To the Complete	Σ.	29b. Signature and We of certifier	mar,	e Bal	29c. Licen.	11		eptembe		
,	18		30. Name and address & pelson who co Rosemarie Butterf:	ield, M.D.	, 110 Baug	ghman's	Lane, Fre	derick,	Marylan	d 2170	)2
**	Sta Registr		31. Date liled (Month, Day, Year) 3 2	32. Resistrar	s Signature	parti					

			1- State of Maryland / Department of Health and M Certificate of Death		20	n.	20000
			1. Decedent's Name (First, Middle, Last)	2. Date of Dea	Reg. Nó. U	UN	3. Time of Death
	Physici		7.	Month	Dav	2004	330 PM
	/Medic Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	10100		ty of Death	5
1	LXGIIII		Blue Point Nursing & Rehab Baltimore			,	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt		9. Birthp	lace (State or Foreign
	Director	Н	340-48-8953 1 M 2 F 74 Yrs. Months Days Hours Min.	A-14	-1929	Seul	h Carolina
	pur *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				
	ahol	7				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-f	Director					
	a or	Ö	10e. Street and Number 25 A5 West Belvedere 21015		10g. Citizen of	SA	itry?
	eath	Funeral	270.0	offy Vas or No-		ice - Americ	an Indian
10	r itar	Fu	Armed Forces? If Yes, specify Cuban Mexican, Puerto F	Rican, etc.)	Bla	ack, White,	
036	al', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☐ No Specify:		Spec	ity: BL	acK,
5-0036	72 hours after death with the Maryland instural; or itams 23a or 28a-f ahow dical Examiter outs be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work in		16b. Kind of i	Business/Inc	dustry
21	within iene. than "	nple.	Elementary/Secondary (0-12) College (1-4or 5+)	ng	1		, .
21	filed w Hygier other th		9			mes	tie
land	d tal	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name  ARTHUR KIRK SR.  Name				
Z	should ind Men s marke umatic	2			chea		
Mary	d 2 sho th and t7 is ma traum		19a. Informant's Name/Relationship (Type, Print) Brother 19b. Mailing Address (Street and Number or Rural ARThur Kirk Jr. 320 N. Carey Street		r, City or Town	1, State, ZIP	Code)
ē,	Health tam 27 other tr				20c. Location	- City or To	wn, State
<b>Baltimore</b>	00		1	31-04		rimor	. ^
Ħ	permit. Pag Department Important: I any injury o		21. Signature of Funer   Secure Licenses   22. Name and Address of Family / 34	N. De	adwa		also ma.
ä	Depar Depar Impo any ir		Miller moller mollers mollers.	lan O	rapel	/	. 21213
			23a. Part Leter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory arr			Approximate
	Pnysician		Immediate Cause (Final disease or condition	4 1000	0		Interval Between Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):	0000	3		
	Examiner		Se wentially list conditions b. Coronary Arsery	PI	reas	8	
	pd ji	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	and -trans	каш	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit		Due to (of as a consequence of).				
387	physicate sthe	dlcal	d				
9 x	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		024 D	ate of deliver	
Вох	atter for u	clar	in the past 12 months?  1				Day Year
0	it the de by the tached	lys	9 Unknown				
J.	s that ned b	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use con	tribute to the	e cause of death?
Records,	w requires been sign should be		Hypothyroidism	1 □ Ye	es 2 (T) No	3 🗆 Proba	ably 4 Unknown
000	> 4 7	ompleted		24a. Was a		Were autop	sy findings available
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Vital	ilcian: Th certificate rector, pag	Be C	25. Was case referred to medical examiner? 26. Place of Death				
of V	Physician: this certific ral director,	으	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ ursing Hom	ne 5 🗌 Reside	ence 6 🗆 Oth	ner (Specify)	)
	ing P	ou:	27. Manger of Death 1 ✓ Natural 5 □ Pending (Month, Day Year) Injury 28b. Time of 28c. Injury at 28c. Injury a	8d. Describe ho	w injury occur	red	
sio	Attanding r death. sctor: After by the funer	catl	2 Accident investigation 3 Suicide 6 Could not be				
=	i Site	Certification:	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (St City or Town		ber or Rural	Route Number,
	pitti ours illie		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, ar	nd due to the ev			
	To the Hospital within 24 hours a To the Funaral C	ledical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and mapper stated.	d at the time, da	ate and place,	and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number		9d. Date signe		
			MJ 19402	-	9-1.	84	
	3		30. Name and address of person who complete cause of death (Item 23a) (Type, Print)  DLV HULL MD 5400 0/8 Court 9	Rd P	1-11.	10/	~
			Dly Ay 16- MD 3 400 0/0 Count 9  31. Date filed (Month, Day, Year) 32. Regignar's Signature	70 ~	111/0	0000	
	Sta Registr		O SEP 1 3 2004 Seem & See				

			1 - For State Registrar	State of Mar		partment of F ertificate of			eņe 1. No. 0 0 4	28887
	Physic /Medi		1. Decedent's Name (First, Middle, Li John Lilly	ist)				2. Date of Death Month 08	2 <sup>pay</sup> 20	3. Time of Death 4:50A
	Examine Funeral Director		243-28-0940	Hospital	In yrs. last birthd 78 Yrs	Silve ay) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y		Death  OMERY  Birthplace (State or Foreig Country)  UNKNUNN
	e Maryland a-f show	ctor	Usual Residence of Decedent  10a. State  10b. County  WAShingha Dish	ict of Columbia	Oc. City, Town o					10d. Inside City Limits
	ath with the 23a or 28	Funeral Director	10e. Street and Number 205 09/2 tha	RPE		10f. Zip Code 200			v. Citizen of Wha	
900	in 72 hours after death with the Maryland "natural", or Itams 23a or 28a-1 show sedical Everyinst Prust by Invitibled at	d by Fune	11. Marital Status U N (CN U) N 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates: UA	.	3. Was Decedent of H If Yes, specify Cubi 1 Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, \	American Indian, White, etc.
21215-0036		Completed by	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. De (G	cedent's Usual Occup ive kind of work done e. DO NOT use retired by NO NO NO NO NO NO NO NO NO NO NO NO NO	during most of worki d)	ing 16	b. Kind of Busin	*
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importants: If item 27 le marked other than any injury or other traumatic event, If at Mence.	To Be C	17. Father's Name (First, Middle, Las					(First, Middle, Ma		unk
	1 and 2 sh Health and em 27 le n thar traun		19a. Informant's Name/Relationship Holy Cross Ho  20a. Method of Disposition	spital	1	ailing Address (Street 500 Forest sposition (Name of	Glen Roa	d Silver	Spring,  City or Town, Sta	MD 20910
Baltimore,	nit. Pages artment of ortant: If it injury or o		1 Burial 2 Cremation 3 ( 1 Donation 5 Other (Spec	Removal from Stafe fy) in state	cemetery, o	erematory or other plac	ca)			
B	permit. Departr Imports any inj		23a. Pa. 1. Enter the disease, if consider the constant of the	pplications that caused the		22. Name and Addre State Anato Saltimore, enter the mode of dyir	MD 21201			Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Sensis	onsequence of):	41				Onset and Death Weeks
68760,	icate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c		irure				Weeks
P.O. Box 68	ath certii attending for use a	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of a large of the larg	Fetal death	3Ectopic pregnancy 5 Other (specify)	,		23d. Date of Month	delivery Day Year
	w requires that the de been signed by the a should be detached it	by	Part II. Other significant conditions  Dehydratic		not resulting in the	e underlying cause giv	en in Part I.		cco use contribut	te to the cause of death? ]Probably 4 ∰nknowr
Vital Records,	(0 ===	Completed						24a. Was an autopsy performe 1 Yes 25	d? deat	e autopsy findings available to completion of cause of h? Yes 2□ No
of	Phye this ral dii	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death	Hospital: 1 XInpatient 28a. Date of Injury	2 ER/Outpa		4   Nuising Hon	ne 5 ☐ Residence Residence Residence Residence Residence		Specify)
Division	or Attanding Fafter death. Diractor: After in by the funer.	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not lead to determined	(Month, Day Y	- At home, farm,		Yes 2 □ No		at and Number o	r Rural Route Number,
	To the Hospital or Attan within 24 hours after deatl To tha Funaral Diractor: completely filled in by the	Medical Co	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysicien: To the best of n miner: On the basis of ex and manner stated	amination and/or	eath occurred at the tin investigation, in my o	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	e(s) and manne and place, and	r as stated. due to the cause(s)
•	To th within To th comp	Me	29b. Signature and little of certifier	Mn		29c. Licenso D323			Date signed (M 08/28/04	onth, Day, Year)
			30. Name and address of person who Suresh K. Gupt	a. M.D. 9801	Georgi	a Ave, Sui	te 220, S:	ilv <b>e</b> r Spr	ing, MD	20902
D:::	Sta Regist	rar	SEP 1 3 20	32 Registrar's	A A	ed .				
υHi	ИН 17 Rev 1/2	:001			ORIGIN					

Mark E. Meushaw 04-05764

	cm		1- For Unpend Item 23atate 05 Maryland Dep 1- State Registra AMEND ITEM #5 PER FH C836 10 Ac	रिकेडिं का कि प्रिकार के स्थाप and strict and strict are strict and strict are strict and strict are strict and strict are strict a	Mental Hygie	2004 28888
	Diversion		Decedent's Name (First, Middle, Last)	7,01.01	2. Date of Death Month	Day Year
	Physici /Medio		Mark Evan Meushaw	-	September	r 06, 2004 8:05 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)  1705 Arlington Avenue, 2nd floor	4b. City, Town, or Location of Deat St. Denis	h	4c. County of Death Baltimore
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday,	) If Under 1 Year   If Under 24 Hrs	8. Date of Birth (Month, Day, Ye	
	Director		218-88-2404 43 Yrs.	Months Days Hours Min.	July 25,	1961 Maryland
	/land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Literature	ocation		10d. Inside City Limits
	a-fsh	ctor	MD Baltimore Relay			1 ☐ Yes 2 ☒ No
	with the	Dire	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?
	ns 23s	Funeral Director	1722 Arlington Ave.  11. Marital Status 12. Was Decedent Ever in U.S. 13.	21227 Was Decedent of Hispanic Origin? (S		nited States  14. Race - American Indian,
9	after or Item	Fun	Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No 3-14-80	If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.
5-0036	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-1 show marked other than "natural", or items 21a to notified at mail cevent, it a Madical Examires mail to notified at	d by	Year or Dates: 9-14-84	1 ☐ Yes 2 ☑ No Specify:	- Feb.	Specify: White
7	n "nat	Completed	life	dent's Usual Occupation skind of work done during most of wor DO NOT use retired)	rking 16t	b. Kind of Business/Industry
212	giene.	Com	Elementary/Secondary (0-12) College (1-4or 5+)	enter		Construction
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Maryland 2121	should be nd Mental nmarked o umatic eve	우	Douglas Meushaw  19a. Informant's Name/Relationship (Type, Print)  19b. Maili	Madeli ing Address (Street and Number or Ru	ine Sauble	
_	ith al 27 ta r trau			Arlington Ave. Re		
Baltimore,			20a. Method of Disposition 20b. Place of Dispo	osition (Name of matory or other place)		c. Location - City or Town, State
Ē	trent of tant: If it	1	4 □Donation 5 □Other (Specify)   Meadowri	dge Memorial 9/10		lkridge, Maryland
Ba	permit. Page Department of Important: If any injury or once.	(	21. Signature of Funeral Service Licensia	2. Name and Address of Facility Am	brose Fune	eral Home, Inc. Simore, Maryland 2122
			23a. Part I. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate
Ŋ	Pnysician i		Immediate Cause (Final disease or condition  Methadone Intoxica	ation		Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
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60,	ficate be executed physician and ts the burial-transit		resulting in death) Last Due to (or as a consequence of):			
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Rox			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
	0 0 0	Physician/M	in the past 12 months?  1 Yes 2 No  1 Ves 2 No	□Ectopic pregnancy □ Other (specify)		Month Day Year
J.	faw requires that the de as been signed by the a 2 should be detached		9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the u	Inderlying cause given in Part I	23e Did tobaco	co use contribute to the cause of death?
Vital Records,	quires n sign uld be	ed by				2 No 3 Probably 4 MUnknown
000	taw require as been si 2 should l	Completed			24a. Was an autopsy	24b. Were autopsy findings available
ĭ z	The ate h page	Con			performed	
<b>V</b>	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  ★② Yes 2 □ No  Hospital: 1 □ Inpatient 2 □ ER/Outpatier	044	th Check on one	
101	On 0 0	$\vdash$	27. Manner of Death 28a. Date of Injury 28b. Time of	IL 3 DOX 4 INdising H	ome 5 Residence 28d. Describe how in	e 6 Mother (Specify) at scene njury occurred
SIO	Attending In death.	catlo	1 Natural 5 Pending investigation 2 Accident 1 Suicide 1 Pending investigation 2 Suicide 1 Pending investigation 2 Pending investigation 3 Suicide 1 Pending investigation 2 Pending investigation 2 Pending investigation 3 Suicide 1 Pending investigation 2 Pending investigation 3 Suicide 1 Pending investigation 3	P M 1 ☐ Yes 2 No	Unknown	
DIVISION	or At after d Direct in by	ertification:	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Could not be determined  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Could not be determined  4 ☐ Homicide  5 ☐ Could not be determined  5 ☐ Could not be determined  6 ☐ Could not be dete		City or Town, St	t and Number or Rural Route Number, tate) 1705 Arlington Ave
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	OI	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death	h occurred at the time, date and place	and due to the cause	e(s) and manner as stated
	the Ho nin 24 the Fu	ledical	(check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)
	Vits CO	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
		ļ	30. Name and address of person who completed cause of death (Item 23a) (Type,	O.C.M.E.	Sej	ptember 07, 2004
			ANA RUBIO, MP 11	1 Penn Street, Ba	ltimore, 1	Maryland 21201
	Sta Registra		31. Date filed (Month, Day, Year) SEP 1 3 2004	Sparks		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Month Nathan Alexander Mosley 7:05PM<sup>M</sup> SEPTEMBER 3 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Numbern/a If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthpface (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Director 1 Sept. 2,2004 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or Itams 23a or 28s-1 show other traumatic event, the Medical Exemplinational be notified at Dundalk 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 1608 Leslie Road 21222 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) N/A Dependent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jacqueline Mosley Paul Dondalski, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1608 Leslie Road Dundalk, Maryland Mrs. Kristina Frye / Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages
Department of
Important: If it
any injury or o ₩ Burial 2 Cremation 3 Removal from State 2St, Joseph Fullerton 9/8/2004 5 Other (Specify) Perry Hall, Maryland 1 4 ☐ Donation 21. Signature of Janeral Sephce Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory d

Due to (or as a consequence of): distress Syndrome **Physician** gay /Medical Examiner pre matur Extreme Sequentially list conditions, it and leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physicien at s the burial-t Box 68760. by Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Hypotension 2 No 3 Probably 4 Unknown Completed hemorrhage Intraventri cular 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 1 ☐ Yes 2 No this 27. Manner of Death 28c. fnjury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Direct 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) augda 4 Tamayo D52295 9/3/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles Street Bultimore, MD 21204 Angela M. Tamaro 60 me 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP1 3 2004 Registrar

Ahan Alexander

hysic /Medi		1. Decedent's Name (First, Middle, Las  Janice Marie	Mantz	-			2. Date of	Death	ay S. E. Yea	3. Time of Death 11:20A
Exami		4a. Facility Name (If not institution, give Saint Joseph	street and number)	ter	4b. City, Tov	wn, or Location	of Death	40	c. County of De	ath timore
uneral rector		5056-40-7081 6. So 056-40-7081 1 Usual Residence of Decedent	ex	last birthday, Yrs.		ear If Under Year Hours	Min. (Month,	Day, Year	9. B 1949 Que	irthplace (State or Fore Country) Ens, New York
show ad at	'n	10a. State 10b. County		ty, Town or L	ocation					10d. Inside City Lim
id other than "natural", or Itams 23a or 28a-f shov event, tre Medical Evantiver i vat be inclified at	Funeral Director	Maryland Baltimore  10e. Street and Number	Tim	onium	10f. Zip Co	de		10g. C	itizen of What (	1 Yes 2 1
23a o	a D	2212 Westridge Road			2109	3		U	SA E	-
tams	nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent If Yes, specify	of Hispanic Or Cuban, Mexica	igin? (Specify Yes or n, Puerto Rican, etc.)	No-	14. Race - Am Black, Wh	nerican Indian, lite, etc.
l', or	b	1 Never Married 2 XMarried 3 Widowed 4 Divorced	1 ☐ Yes 2/5/No If Yes, Give Year or Dates:		1 ☐ Yes 2 😾				Specify:	hite
nature lical	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usual O	ccupation	et of working	16b. h	(ind of Busines	
han "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	112.2		lone during mos etired)	t or working			
ther th		12 17. Father's Name (First, Middle, Last)	N/A	Office	Manager Manager		er's Name (First, Mide		Estate	Industry
is markad other than aumatic event, II e Ms	To Be	Edward Milligan					e Heinschn	ole, Maldel	n Sumame)	
item 27 Is marka other traumatic	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (St	reet and Number	er or Rural Route Nur	nber, City	or Town, State,	Zip Code)
m 27 her tr	18	Stephen F Mantz	200-5				imonium, Mar	-		
Important: If item 27 is any injury or other tra once.		20a. Method of Disposition  1) Purial 2 Cremation 3	Removal from State	emetery, cre	osition (Name of matory or other	place)	Date		ocation - City o	
ortant injury t.		<ul><li>4 □ Donation 5 □ Other (Specify</li><li>21. 3 of the funeral Service License</li></ul>				Septe, b ddress of Facili	er 13 2004	Balt	imore, Ma	ryland
any ir		Mortinistron	n Chamber	2.	Lassahn l	Funeral H	lame Inc	(or <b>a</b> 1) ora	.1 21226	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	dications that caused the deat	h. Do not en	ter the mode of	dying, such as	Baltimore, M cardiac or respiratory	arrest,	11 21230	Approximate
sician		Immediate Cause (Final disease or condition	RESPIRATO	RY FA	ILURE					Interval Between Onset and Death
edical miner		resulting in death)	Due to (or as a conseq	uence of):		ch temperates				
	er	Sequentially list conditions,	b. Due to (or as a conseq		mai um	HARMETA				7 YEARS
physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	uence of):						
by the attending ph tachad for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1  Live birth 2  Feta 4  Pregnant at time of d 9  Unknown	I death 3	Ectopic pregna	ancy			23d. Date of de Month	Blivery Day Year
pg ep	by Ph	Part II, Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause	given in Part I.	23e. Di	d tobacco i	use contribute t	to the cause of death?
baen sign should be	leted b						1[	Yes 2	<b>X</b> No 3□P	robably 4 DUnknov
age 2	Complet			-	-			topsy rformed?	prior to death?	utopsy findings availab completion of cause of
certifica rector, p	Be (	25. Was case referred to medical examiner?				26. Place	of Death (Check only			
Sill	.T	1 Yes 2 No	Hospital: 1 Inpatient 2   28a. Date of Injury	ER/Outpatier 28b. Time of			rsing Home 5 Re			ecify)
After th funeral	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		Injury at Work? 1 ☐ Yes 2 ☐ I	28d. Describ	e now injui	у оссигва	
d in by the f	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str			28f. Location	(Street an own, State	d Number or R )	ural Route Number,
To the Funerel Direc completely filled in by	edical C	29a. Certifier (Check only one) 2 Medical Exami	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or in	occurred at the	e time, date an ny opinion, deal	d place, and due to the	e, date and	and manner as I place, and due	s stated. e to the cause(s)
To the complet	×	29b. Signature and title of certifier	11		29c. Lic	ense number			te signed (Mont	- '
		1 (Yand	/ May sol		D	16587		C	Acu be	9,2004
		O Close	Cr / /	10.000				400	to gove or	7 ()200/

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	Examii	ner	4a. Facility Name (If not institution, give Harbor Hospila	l Cente			B	Balti	more	2			County o		
	Funeral Director		5. Social Security Number 6. Security Number 10 Sec	X 7. Ag	e (In yrs. last I	Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of B (Month, D Nov. 1	$\stackrel{\text{irth}}{4}, \stackrel{\text{Year}}{1}$	934	9. Birthpl Count Mar	ace (State or Foreign ry) yland
	he Maryland 8e-f show otified at	ector	10a. State 10b. County Maryland N/A		10c. City, To	wn or Lo	re								d. Inside City Limits 1X Yes 2 □ No
	h with t	al Dire	10e. Street and Number 3524 - 6th Street	et			10f. Zip	Code 2122	:5				zen of W U.S.	hat Count	ry?
5-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-f show or other freumatic event, the Modical Examinate sustained at	d by Funeral Director	11. Marital Status  1   Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No		I□Yes 2	No No	Specify:	in? (Spe Puerto	ecify Yes or N Rican, etc.)	1	Black	- America , White, e Whi	tc.
21215-	d within 72 l piene. r than "nat	Completed	15. Decedent's Edd (Specify only highest grad Elementary/Secondary (0-12) 12th	ucation de completed) College (1-4or 5		(Give life. L	lent's Usua kind of wor DO NOT us ounti	k done di e retired)	tion uring most	of worki	ing			Co.	Imports
Maryland 2	12 should be filed within in and Mental Hygiene. 7 is marked other than "reumatic event, It. M. d.	To Be C	17. Father's Name (First, Middle, Last)  John G.							Vio	(First, Middle let Tuc	dor			
Mar	nd 2 sho lith and 27 is m		19a. Informant's Name/Relationship (T)  Lynn Tucci / Sis				g Address • Pat				Route Numb				Code) Land 21225
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any njury or other tre QDC8		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specify,	Removal from State	20b. Place	of Dispo	sition (Nam	e of her place	) !	D	) <sub>ate</sub> /2004	20c. Loc	cation - C	ity or Tow	,man
Balti	permit. Departn Imports any nju		21. Signature of Funeral Service Licens	emuo	with	40	Name and	Address Ltchi	of Facility	Go: ghwa	nce Fu y Ba				, P.A. land 21225
8760,	Any sician and hysician and hysician and the burial-transit	dical Examiner	23a. Fart1. Enter the disease of comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. First Understa	Due to (or as	a consequence	e ill fai	line	ances	to effect		eumo		an	C	Approximate niterval Battween Dnset and Death N K nown
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deat		Ectopic pre Other (spe					23	3d. Date Monti	of delivery	ay Year
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions co.	ntributing to death be			derlying ca	use giver	in Part I.	e	23e. Did 1	/			cause of death?
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of Vital	d is	To Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \)	Hospital: 1 Inpatie	nt 2 ERVC	utpatient	3 DOA				Check onl		Other	(Specify)	
o uoi	nding Ph th. : After th e funeral		27. Manner of Death  1 Patural 5 □ Pending 2 □ Accident investigation	28a. Date of Injui (Month, Day	y Year) 28b.	Time of Injury	28 M	c. Injury a Work?	at es 2 □ No	2	8d. Describe				
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	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best oner: On the basis of and manner sta	examination a	e, death nd/or inv	occurred a estigation, i	t the time n my opii	, date <i>a</i> nd nion, death	place, a	nd due to the d at the time,	cause(s) a date and p	ind mann place, and	ner as stated	ed. e cause(s)
		Me	29b. Signature and title of certifier  Dr. Aslinia	VAS	Pinic	2	29c.	License i		77		29d. Date Septo			y. Year) , 2004
	8	1		mpleted cause of de	eath (Item 23a) S Har		Print)	rect	, F	Balt	insn	2 2	1/22	2-5	MD
	Sta Registr	-	31. Date filed (Month, Day, Year) SFP 1 3 2004	ALC:	ar's Signature	and!	,								

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of I rtificate of			giene leg.No. 1	28892
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea	er <sup>Day</sup> 10 2004	3. Time of Death
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	Examin	er	Holly Hill Ma		)	Towson	or Location of Death	1	Baltim	ore
	Funeral Director		212-30-3329	ex 7. A □ M 2 🛣 F	ge (In yrs. last birthday, 89 Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day March	9. Birthe 6, 1915 Ma	place (State or Foreign ntry) ryland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation			1	10d. Inside City Limits
	Mary a-fsh	tor	Md. Baltim	ore	Hydes					1 ☐ Yes 2 🗶 No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Cour	-
	eath v	Funeral	5818 Church Lane	12. Was Deceden	t Ever in U.S. 13		082	necify Yes or No-	14. Race - Americ	
920	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23e or 28e-f show event, the Medical Examiner must be notified at event,	ρχ	1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces  1  Yes 2  If Yes, Give Year or Dates	? ]No	If Yes, specify Cub	dispanic Origin? (S) an, Mexican, Puert Specify:	Rican, etc.)		
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р Б	filed Hygi sthar ant, I	a)	17. Father's Name (First, Middle, Last)		Homen	iaker	18. Mother's Nan	ne (First, Middle, i	Own Home Maiden Sumame)	
ılan	2 should be and Mental is markad c	lo B	Frank Pasek				Rache1	Dermac	:k	
Baltimore, Maryland 21215-0036	s 1 and 2 should f Health and Men tam 27 is marka othar traumatic	•	19a. Informant's Name/Relationship (7			_			r, City or Town, State, Zip	Code)
e, z	s 1 and 2 of Health a Itam 27 is othar trai		Mr. Donald Meachar  20a. Method of Disposition	n/ Son	5818 20b. Place of Disp		Lane Hyde		21082 20c. Location - City or To	own State
nor	ages ant of l it: If It: y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify		nomotoni oro	matory or other pla	<sup>сө)</sup> 9 <b>-1</b> 3		Pikesville,	
altir	permit. Pages. Department of the Important: If Its any injury or of once.		21. Signature of Funeral Service Ligen							riu.
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8760,	cate be executed /Medical Examiner bhysician and the burial-transit the burial-transit	dical Examiner	23a. Part 1. Enter the disease, of composition shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. List underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a b. Due to (or a c.	s a consequence of): consequence of): s a consequence of):	uter;		erse		Approximate Interval Between Onset and Death
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Δ.	ires that signed b	by PI	Part II. Other significant conditions of	ontributing to death	but not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	bacco use contribute to th	e cause of death?
ord	w requir been si should	ted	opstructive la	ing dis	eese, at	rial piper	Matian	1 Ye	es 2 No 3 Prob	ably 4 🗷 Unknown
al Records,	The lay ate has page 2	Completed	dementia,	diabet	es, 05 V	eoper	2120	24a. Was a autops perform	y prior to cor ned? death?	psy findings available inpletion of cause of
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Divis	tal or Attandi s after death. al Diractor: A ed in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	200. Place of Ir	njury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office		28f. Location (St. City or Town	reet and Number or Rura n, State)	l Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Diract completely filled in by	edical	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the bes niner: On the basis and manner s	of examination and/or in	h occurred at the til vestigation, in my o	ne, date and place, pinion, death occur	and due to the carred at the time, da	ause(s) and manner as st ate and place, and due to	ated. the cause(s)
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7	./		20 No.		1-20	Dian's	4110	7	2-10.	4
	り		30. Name and address of person who	completed cause of	Seath (Item 23a) (Type,	ork R	coad T	ouso	MMD 2	1204-
14	⊱ Sta Registr	_	31. Date filed (Month, Day, Year) SEP 1 3 2	32. Jegist	trar's Signature	book		· · · · · · · · ·		

			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of H			iene	28893	
4	Physic	an	Decedent's Name (First, Mid					2. Date of Dear Month	_	3. Time of Death	
	Medic Examine the Maryland or items 238 or 288-1 show the rectified at the	cal	Susana		artinez	T		September 4, 2004 3:30 PM			
		Director	4a. Facility Name (If not instituti			4b. City, Town, or		th	4c. County of I		
			Manor Health  5. Social Security Number		Pring Age (In yrs. last birthday)		Spring If Under 24 Hrs	S O Date of Birth	Montgomery		
			579-64-9631 Usual Residence of Decedent	1 □ M 2 <b>X</b> F	98 Yrs.	Months Days	Hours Min			Birthplace (State or Foreign Country) <b>Ecuador</b>	
			10a. State 10b. Coun	ty	10c. City, Town or Le	ocation				10d. Inside City Limits	
			Maryland Mon	tgomery	Silver	Spring				1 ☐ Yes 2 🗶 No	
			10e. Street and Number		10f. Zip Code		1	10g. Citizen of What Country?			
			901 Arcola A	venue		2090	02	United States			
5-0036		by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Give	<b>X</b> No	Was Decedent of Hi If Yes, specify Cuba 1  Yes 2 □ No	n, Mexican, Pue	Specify Yes or No- to Rican, etc.)		American Indian, Vhite, etc.  White	
2-0	72 hours "naturel",	Completed	15. Decede	ent's Education rest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of worki		adela a	16b. Kind of Busine	3b. Kind of Business/Industry	
2121	be filed withir tal Hygiene. d other than event, the Me		Elementary/Secondary (0-12)			life. DO NOT use retired)  Nanny			Dome	Domestic	
Maryland		To Be C	17. Father's Name (First, Middle Unknown	e, Last)			18. Mother's Na	me (First, Middle, M	Maiden Surname)		
ary	ts bus me	F	19a. Informant's Name/Relation	nship (Type, Print)	19b. Maili	ng Address (Street a			City or Town, Star	e, Zip Code)	
	s 1 and 2 should f Health and Men item 27 is marke other treumatic		Carmen A. F	Pulupa (POA)	171	2 Tilton	Dr., Si	lver Spri	ng, Md.	20902	
Baltimore,	Page lent o nt: if ry or		20a. Method of Disposition  1 Burial 2 Cremation  1 Donation 5 Other		20b. Place of Dispo cemetery, crea	esition (Name of matory or other place ike Cremat	9) 0/		Beltsvi	or Town, State	
Balt	permit. Pa Deportmen Importent any njury once.		21. Signature of Fineral Service	e Live see	la mil I	2. Name and Addres  Rapp Funer  33 Gist A	al and	Cremation	Services		
			232. Part1. Enter the disease, shock, or heart failure. Lis	or complications that cause on each	sed the death. Do not ent	er the mode of dying	g, such as cardia	c or respiratory arre	st,	Approximate	
	Pnysician	19	Immediate Cause (Final disease or condition	/ composition of the composition		V		molant	7-	Interval Between Onset and Death	
	/Medical		resulting in death)	aDue to (or	as a consequence of):	work	n ind	pa-siting !	we com	mores	
	Examiner		Sequentially list conditions,	b	Hanscher	-				400-11	
	be sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of):						
_	cate be executed physician and the burial-transit	хап	that initiated events resulting in death) Last	C. Due to for	as a consequence of):						
8760,	cate be execut ohysician and the burial-trar	a E	Due to (or as a consequence of):								
687	ficate phys	dlcal		d							
P.O. Box (	The law requires that the death certification is the been signed by the attending to age 2 should be detached for use as	Completed by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		1 2 Fetal death 3 t at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year	
	w requires that been signed b should be deta		Part II. Other significant condit	tions contributing to deat	h but not resulting in the u	nderlying cause give	n in Part I.	23e. Did tob		e to the cause of death?  Probably 4 Unknown	
SOF	v requ been shoul	etec	2	34	tole		-	-			
al Records,	ng Physicien: Iter this certifica neral director, I	To Be	several a	lend both	Quelal	mle	70	24a. Was an autopsy perform	prior	autopsy findings available to completion of cause of ? es 2 No	
Vital			25. Was case referred to medic examiner?	Hospital:		Othe		ath (Check only one	)		
o			1 ☐ Yes 2 ☐ No 27. Manner of Death	1 🗆 Inp.		5 ☐ Residence 6 ☐ Other (Specify)					
OU			27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 2 ☐ Accident investigation 4 28c. Describ							e how injury occurred	
Division	or Atten ifter deat Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of	Injury - At home, farm, str etc. (Specify)		03 2	28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,	
	pitel	Ce	200 Codding 1 Xoodifu	in a Dhuainin a Tarib							
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	one)	and manner	st of my knowledge, death s of examination and/or inv stated.	estigation, in my op	inion, death occu	rred at the time, da	te and place, and c	lue to the cause(s)	
	Will To COn	<	29b. Signature and title of certifi	er		29c. License	number		d. Date signed (Mo		
	$\wedge$		Lling	2 6 Gra	nam , dy	00	3188	6	9-07-3	2004	
	7	1	7 00 0	- GRAZIA	wi mus	Print) 712 P	PASHING N SP	- On me	20 20	910	
	Sta Registr		SEP 1 3 200		strar's Signature	backs		(			

		Registrar			Cer	tificate of	Death		Reg. No.	Inni	2000	
Physician /Medical	13	Decedent's Name (First, Middle, Last)     CLEO MICHAEL					2. Da Mo SEI			2004	3. Time of Dec	
Examiner								County of Death	1			
uneral rector			Sex 7. XXM 2□F	Age (In yrs. 93	last birthday) Yrs.	If Under 1 Yea Months Days		in. (Month,	Birth <i>Day, Year)</i> <b>19-11</b>	Cou	nplace (State or Fountry)	
-f show fied at	1	10a. State 10b. County			y, Town or Loc						10d. Inside City L	
3a or 28a-1 si	1	Oe. Street and Number	en Road	n Road			10f. Zip Code <b>21244</b>			10g. Citizen of What Country? U.S.A.		
If itam 27 is marked other than "natural", or itams 23a or 28a-1 show or other traumatic event, the Medical Exercited must be notified at To Be Completed by Funeral Director	2	1. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? <b>⋉</b> No	1	☐ Yes <b>※</b> No	Specify:	(Specify Yes or I erto Rican, etc.)		14. Race - Amer Black, White Specify: <b>Bla</b>	, etc. LCK	
is marked other then "nature reumatic event, the Medical E	_	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 2+  17. Father's Name (First, Middle, Last)			16a. Decedent's Usual Occupation (if work done during most of working life. DO NOT use retired)  Youth Counselor  18. Mother's Name (First, Middle)			16b. Kind of Business/Industry  D. C. Child Ren Ce				
arkad otl atic evan To Be	5	Franklin C		el			Es	tella 1	Горр	,		
27 is m		19a. Informant's Name/Relationship Anita William		ter				Rural Route Num Catons				
Important: If itam 27 is any injury or other trae once.	2	20a. Method of Disposition  1 Parallel 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci	□Removal from Sta	ate C	emetery, crem	sition (Name of natory or other pla morial		Date /15/04		cation - City or T		
Importent: If any injury o once.	2	21. Signatur Funeral Service Lice	, Hacket	+ A.	22. I	Name and Addr Hackett B14- Ur	ess of Facility S Fun	eral Ch treet,	napel	, Inc.		
sician edical	1	23a. Fart1. Inter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	h line.				,,	1		Approximate Interval Between	
nysician and he burial-transit and he burial-transit and learn and	o o	Sequentially list conditions, and second to mediate acuse. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	b	as a consequate as a consequence as a	nienca uf):	Cere	thyal V	ascula	disa	ase	Onset and Dea	
g physician and as the burial-transit edical Examiner	o o o	Sequentially list conditions, by leading to mindel the cause. Enter Underlying Cause (Disease or injury hat initiated events	b	as a consequence of pregnan 2 Feta t at time of di	uence of):	Ectopic pregnant Other (specify)		ascula		23d. Date of delive	years ery	
gned by the attending physician and be detached for use as the burial-transit by Physician/Medical Examiner	t r	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events resulting in death) Last  F FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	b. Due to (or  d.  23c. If yes, outcor 1	as a consequence of pregnan 2 Feta tat time of din	uence of):  uence of):  uence of):  uence of):	Ectopic pregnand Other (specify) _	cy	23a. Dic	2 d tobacco us	23d. Date of deliv Month se contribute to t	ery Day Yea	
been signed by the attending physician and should be detached for use as the burial-transit leted by Physician/Medical Examiner	C C C C C C C C C C C C C C C C C C C	Sequentially list conditions, any leading to immodule cause. Enter Underlying Cause (Disease or injury hat initiated events resulting in death) Last  F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	b. Due to (or  d.  23c. If yes, outcor 1	as a consequence of pregnan 2 Feta tat time of din	uence of):  uence of):  uence of):  uence of):	Ectopic pregnand Other (specify) _	cy	23e. Dic 1 [ 24a, Wa	tobacco us  Yes 25 s an opsy formed?	23d. Date of delive Month  se contribute to te  No 3 □ Prole  24b. Were aut	ery Day Yea  the cause of deat bably 4 □Unki	
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Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit striffication; To Be Completed by Physician/Medical Examiner	P 2	Sequentially list conditions, any leading to immodiate cause (Disease or injury hat initiated events esulting in death) Last  FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the cause of the conditions of the cause of the ca	b. Due to (or  c. Due to (or  d.  23c. If yes, outcor  1	as a consequence of pregnan 2 Feta tat time of don h but not result in the but not resul	uence of):  uence of):  uence of):  uence of):  locating a substituting in the understand substitution substituting in the understand substituting in the understand substituting in the understand substituting in the understand substituting in the understand substitution	Ectopic pregnand Other (specify) _ derlying cause gi  3 □ DOA  28c. Inju Wd M 1 □ et, factory, office	26. Place of 0 her:  4 Nursing ry at rk?  Yes 2 \ No ime, date and pla opinion, death oc	23a. Did  24a. We put put put put seath (Check only Home 5 Re 28d. Describe  28f. Location City or Ti	I tobacco us  Yes 25  Is an opsy of one)  sidence 6  how injury  (Street and own, State)  e cause(s);  d, date and	23d. Date of delive Month  Se contribute to the second se	ery Day Year the cause of death bably 4  Unkr popsy findings avai impletion of cause 2  No fy) al Route Number, chated. to the cause(s)	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. UU4 . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Margaret Charlotte Nemcek /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hoseda If Under 1 Year Franklin Square Hospital
5. Social Security Number 6. Sex Center If Under 24 Hrs. Timore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 212 46 5983 1 ☐ M 2 🖾 F 60 Director Oct.30,1943 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or items 23a or 28e-f show other treumatic event, the Modical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2€ No Director Maryland Baltimore Eastpoint 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8001 Wynbrook Rd. 21224 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White ges 1 and 2 should be filed within 72 hours t of Health and Mental Hygiene. If item 27 Is marked other than "naturel", Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Abel Margaret Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Adam Nemcek(Husband) 8001 Wynbrook Rd. Baltimore, Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ott 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gardens 9/13/2004 Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Sign ture of Funeral Service-License 1407 Old Fastern Avenue Essex, 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final StageCOP **Physician** End disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ore Pylmonale Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, nding physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery atter 1 Live birth 2 Fetal death 3 Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I the detached 9 Unknown 9 Unknown cate nas been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed certificate Division of Vital 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending r death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Fune completely fi Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0006133 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 square Drive Baltimore, Md 21237 Kirmani 31. Date filed (Month, Day, Year) State SEP 1 3 2004 Registrar

Vemceh, Margaret

		1- State of Maryland / State of Maryland /	Department of Health and Menta Certificate of Death	al Hygiene						
Physicia /Medic	al	1. Decedent's Name (First, Middle, Last)  Betfy Og Jen  4a. Facility Name (If not institution, give street and number)		te of Death onth Day Year 3. Time of Dea						
Examine Funeral Director	er	EllCurist  5. Social Security Number $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	Tonson rthday) If Under 1 Year   If Under 24 Hrs.   8, Dat	4c. County of Death  Balthore  9. Birthplace (State or For County)  Marvland						
e-f ehow	ctor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Tow           Maryland         Howard         Elkri		10d. Inside City Li 1 X Yes 2 □						
23e or 28 ust be no	Completed by Funeral Director	10e. Street and Number 6117 Downs Ave.	10f. Zip Code 21075	10g. Citizen of What Country? U. S. A.						
"neturel", or flems 23e or 28e-f ehow sdical Evandric must be notified at		11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☒ No Specify:	es or No- etc.)  14. Race - American Indian, Black, White, etc.  Specify: White						
ital Hygiene. id other then event, the Me		(Specify only highest grade completed)  Elementary/Seophdary (0-12)  College (1-4or 5+)  H	. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Omemaker	16b. Kind of Business/Industry Own Home						
	To Be	17. Father's Name (First, Middle, Last)  Clarence Seaton  19a. Informant's Name/Relationship (Type, Print)  19t	Addie Rudol	Name (First, Middle, Maiden Surname)  Rudo1ph  r Rural Route Number, City or Town, State, Zip Code)						
f Health and Meritem 27 is marke		Sharon D. Walker, daughter 5	812 Victor Dr. Sykesvi							
Department of H Importent: if itel eny injury or ott once.		1 🛣 Burial 2 □ Cremation 3 □ Removal from State  1 □ Cremation 3 □ Removal from State  1 □ Cremation 3 □ Cremation 3 □ Crematical State  1 □ Cremation 3 □ Cremation 3 □ Crematical State  1 □ Cremation 3 □ Cremation 3 □ Crematical State  1 □ Cremation 3 □ Cremation 3 □ Crematical State  1 □ Cremation 3 □ Cremation 3 □ Crematical State  1 □ Cremation 3 □ Cremation 3 □ Crematical State  1 □ Cremation 3 □ Cremation 3 □ Crematical State  1 □ Cremation 3 □ Cremation 3 □ Crematical State  1 □ Cremation 3 □ Crematical State  1 □		20c. Location - City or Town, State -04 Sykesville, MD.						
Depar Impor eny in once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD 21227  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate								
hysicia the bur	dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate failure. Finit in harrying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence condition).  Due to (or as a consequence condition).	of): OZ of):	Interval Betwee Onset and Dea Week S						
by the attending p tached for use as	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Yea						
been signed b should be deta	Completed	Part II. Other significant conditions contributing to death but not resulting in Hyper tension, Myocardical Infa		e. Did tobacco use contribute to the cause of deat						
icate has				a. Was an autopsy findings ava prior to completion of cause death?  Yes 2 № No 1 ∨ Yes 2 № No						
his II dii	sation: To Be	1 SNatural 5 Pending (Month, Day Year) 2 Accident investigation		Nursing Home 5 ☐ Residence 6 Nother (Specify) 110 Spi L ≥ 28d. Describe how injury occurred ☐ No						
	l Certification:									
	CC	(Check only 2 Medical Examiner: On the basis of examination ar	to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)							
in 24 hou he Fune pletely fil	edical	one) and manner stated.								
within 24 hou  To the Fune  completely fi	Medic	29b. Signature and title of certifier	29c. License number D00611 9 9	Sept, 11 2004						

at 11:15 Am

September 11, 2004

Ogden , betty

Powell, Philip Clark
Baltimore, Maryland 21215-0036

	1 - For State Registrar	, , , , , , , , , , , , , , , , , , , ,	Department of Health and Mo Certificate of Death	Reg. No	2001 000-
	1. Decedent's Name (First, Middle,	Last)		2. Date of Death Month Qa	y Year / 3. Time of Death
an cal	Philip C. Powe	ell		9 8	2004 5:251
er	4a. Fecility Name (If not institution,	0 11 0	4b. City, Town, or Location of Death	40	County of Death
J		6. Sex 7. Age (In yrs. last b	birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreig
		1 <b>⊠</b> M 2□F	Yrs. Months Days Hours Min.	(Month, Day, Year)	Country)
	235-30-2733 Usual Residence of Decedent	77		01/19/1927	
<u>.</u>	10a. State 10b. County	10c. City, To	own or Location		10d. Inside City Limit
Director	MD Balti	more White	e Marsh	100 Ci	tizen of What Country?
	10e. Street and Number				
Funeral	11623 Jerome A	12. Was Decedent Ever in U.S.	21162  13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - American Indian, Black, White, etc.
5	1 Never Married 2 Marrie	Armed Forces? ad 1 ☐ Yes 2 ☑ No		Rican, etc.)	Black, White, etc.
2	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White
מנטני	15. Decedent's (Specify only highest		Sa. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	16b. K	(ind of Business/Industry
ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		
Completed	17. Father's Name (First, Middle, L.	astl	Cocktail Lounge Owner	(First, Middle, Majder	If Employed
Be				16	
မှ	Arless E. Power 19a. Informant's Name/Relationship		9b. Mailing Address (Street and Number or Rural	M. Ashcra	
			00/205	27	
	Brenda Hinton 20a. Method of Disposition	20b. Place	of Disposition (Name of D		sh MD 21162 ocation - City or Town, State
	1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp.	3 Hemoval from State	etery, crematory or other place)		
	21. Signature of Funeral Service L	TEL /	Air Memorial Gds 09/1	1/2004 Be	L Air, Maryland
			22. Name and Address of Facility L	F Laccahn	funoral Homo D 7
	PE XX	sandal			funeral Home, P.A
_	23a. Part1. Enter the disease, or o	complications that caused the death. D	11750 Belair Road —	Kingsvill	e, Maryland 21087
	shock, or heart failure. List o	complications that caused the death. D	11750 Belair Road —	Kingsvill	e, Maryland 2108
	shock, or heart failure. List o	complications that caused the death. D	11750 Belair Road — to not enter the mode of dying, such as cardiac of the control of the contro	Kingsvill	e, Maryland 21087 Approximate Interval Between
	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that caused the death. Donly one cause on each line.  a. Due to (or as a consequence)	11750 Belair Road — to not enter the mode of dying, such as cardiac of the control of the contro	Kingsvill	e, Maryland 21087 Approximate Interval Between
ner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Tarry leading to immediate	complications that caused the death. D inly one cause on each line.	11750 Belair Road — to not enter the mode of dying, such as cardiac of the control of the contro	Kingsvill	e, Maryland 21087 Approximate Interval Between
aminer	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	complications that caused the death. Dunly one cause on each line.  a. Due to (or as a consequence)  b. Due to (or as a consequence)  c.	11750 Belair Road — To not enter the mode of dying, such as cardiac or the first control of the mode of dying and the mode of	Kingsvill	e, Maryland 21087 Approximate Interval Between
Examin	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 and 1 an	complications that caused the death. Donly one cause on each line.  a. Due to (or as a consequence b.	11750 Belair Road — To not enter the mode of dying, such as cardiac or the first control of the mode of dying and the mode of	Kingsvill	e, Maryland 21087 Approximate Interval Between
Examin	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 and 1 an	complications that caused the death. Dunly one cause on each line.  a. Due to (or as a consequence)  b. Due to (or as a consequence)  c.	11750 Belair Road — To not enter the mode of dying, such as cardiac or the first control of the mode of dying and the mode of	Kingsvill	e, Maryland 21087 Approximate Interval Between
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Examin	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 and 1 an	b. Due to (or as a consequence d	11750 Belair Road — To not enter the mode of dying, such as cardiac of the configuration of t	Kingsvill	e, Maryland 21087 Approximate Interval Between
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by Physician/Medical Examin	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Tarry leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition	b. Due to (or as a consequence d. Due to (or as a consequence	11750 Belair Road — Do not enter the mode of dying, such as cardiac or the of):  De of):  De of):  Ath 3 Dectopic pregnancy The office of the control of the	Kingsvill r respiratory arrest,	e. Maryland 2108  Approximate Interval Between Onset and Death  23d. Date of delivery Month Day Year  use contribute to the cause of death?
by Physician/Medical Examin	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Tarry leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition	b. Due to (or as a consequence d. Due to (or as a consequence	11750 Belair Road — Do not enter the mode of dying, such as cardiac or the of):  De of):  De of):  Ath 3 Dectopic pregnancy The office of the control of the	Kingsvill r respiratory arrest,  23e. Did tobacco	e. Maryland 2108  Approximate Interval Between Onset and Death  23d. Date of delivery Month Day Year  use contribute to the cause of death?
by Physician/Medical Examin	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Tarry leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition	b. Due to (or as a consequence d. Due to (or as a consequence	11750 Belair Road — Do not enter the mode of dying, such as cardiac or the of):  De of):  De of):  Ath 3 Dectopic pregnancy The office of the control of the	23e. Did tobacco	23d. Date of delivery Month Day Year  23d. Were autopsy findings availab prior to completion of cause of death?
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o Be Completed by Physician/Medical Examin	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 ary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence complete to (or as a consequence co	11750 Belair Road — Do not enter the mode of dying, such as cardiac of the conficient of the conficien	23e. Did tobacco  1 Tyes 2  24a. Was an autopsy performed? 1 Ves 2 No. (Check only one)	Approximate Interval Between Onset and Death  23d. Date of delivery Month Day Year  Use contribute to the cause of death?  No 3 Probably 4 Unknow  24b. Were autopsy findings availab prior to completion of cause of death?  1 Yes 2 Ne
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To Be Completed by Physician/Medical Examin	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence of Due to (or as a consequence	11750 Belair Road — Do not enter the mode of dying, such as cardiac of the control of the contro	23e. Did tobacco  1 Yes 2  24a. Was an autopsy 1 Yes 2 No. (Check only one)  me 5 Residence 28d. Describe how inju	Approximate Interval Between Onset and Death  23d. Date of delivery Month Day Year  use contribute to the cause of death?  No 3 Probably 4 Unknow  24b. Were autopsy findings availab prior to completion of cause of death?  1 Yes 2 We
Certification: To Be Completed by Physician/Medical Examin	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 and the cause of the cause of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 we see 1 who see 1 who see 1 when the past 12 months? 1 when the past 12 months? 1 when the past 12 months? 1 when the past 12 months? 1 when the past 12 who see 1 when the past 12 wh	complications that caused the death. Donly one cause on each line.  a. Due to (or as a consequence of the co	11750 Belair Road — Do not enter the mode of dying, such as cardiac of the control of the contro	23a. Did tobacco  1  Yes 2  24a. Was an autopsy performed? 1 Yes 2 No. (Check only one)  me 5 Residence 28d. Describe how injuication of the cause (street a City or Town, State and due to the cause (state)	Approximate Interval Batween Onset and Death  23d. Date of delivery Month Day Year  use contribute to the cause of death?  UNO 3 Probably 4 Unknow  24b. Were autopsy findings availab prior to completion of cause of death?  1 Yes 2 UNO  6 Other (Specify)  and Number or Rural Route Number.  e)
edical Certification: To Be Completed by Physician/Medical Examin	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	complications that caused the death. Donly one cause on each line.  a. Due to (or as a consequence of the co	26. Place of Death Coutpatient 3 DOA  b. Time of Injury M  1 Types 2 No  1, 1arm, street, factory, office  do not enter the mode of dying, such as cardiac or the content of the mode of dying, such as cardiac or the c	23e. Did tobacco  1 Yes 2  24a. Was an autopsy performed? 1 Yes 2 No. (Check only one)  me 5 Residence 28d. Describe how injunction (Street a City or Town, State and due to the cause(sed at the time, date and	Approximate Interval Between Onset and Death  23d. Date of delivery Month Day Year  use contribute to the cause of death?  Use Contribute to the cause of death?  24b. Were autopsy findings availabe prior to completion of cause of death?  1 Yes 2 Ne  6 Other (Specify)  uny occurred  and Number or Rural Route Number, e)  3) and manner as stated.  d place, and due to the cause(s)
Certification: To Be Completed by Physician/Medical Examin	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	complications that caused the death. Donly one cause on each line.  a. Due to (or as a consequence of the co	11750 Belair Road — Do not enter the mode of dying, such as cardiac of the control of the contro	23e. Did tobacco  1  Yes 2  24a. Was an autopsy performed? 1 Yes 2  No. (Check only one) me 5  Residence 28d. Describe how inju 28f. Location (Street a City or Town, State and due to the cause(sed at the time, date an	Approximate Interval Batween Onset and Death  23d. Date of delivery Month Day Year  use contribute to the cause of death?  UNO 3 Probably 4 Unknow  24b. Were autopsy findings availab prior to completion of cause of death?  1 Yes 2 UNO  6 Other (Specify)  and Number or Rural Route Number.  e)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
SEP 13 2004

who completed cause of death (Item 23a) (Type, Print)

Shart WI- 109 Row River Well

32. Pegistrar's Signature

April

MDZRZI

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Dey **Physician** EBB August 24, 2004 4:25 PM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Charles Village Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Yeer) Sept 6, 1958 Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□ F 349-56-3527 45 Director Virginia Usuel Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.
ther than "natural, or itams 23s or 28s-f show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Funeral Director Baltimore 1 Yes 2 □ No 10e Street end Number 10f. Zip Code 10g. Citizen of What Country? re 23a or 2327 N. Charles Street 21218 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: Completed by black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) engineer architecture Saltimore, Maryland 17. Fether's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Depertment of Health end Mental Hy Important: If item 27 ia meriked other any injury or other traumetic event unk 18. Mother's Name (First, Middle, Maiden Surname) Be Webb Perdue Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Belinda Simon/friend 5633 Belle Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4□Donation 5 XOther (Specify) in state 21. ature neral Ser 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street <sup>celicensee</sup> S. Wade⊿Director Baltimore, MD anna 21201 at one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner by Physician/Medical Examiner buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ( r as e consequence of): Box 68760. Due to (or as e consequence of) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed certificate has 211No tu Yes 1 ☐ Yes 2 ☐ No within 24 hours effer death.

To the Funaral Director: After this certifica completely filled in by the funeral director. or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Medicai Certification: To 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mannet of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29c. License number 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 2 D17537 9-3-04 Baltimore 21217 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 1600 W. MOUNT Loyal Ave, SALUIA DARSHAN 5.

Registrar

DHMH 16 Rev 6/95

State

31. Date filed (Month, Pay, Year) SEP 1 3 2004 32. Registrar's Signature

			For State Registrar	State of Marylar		artment of Hertificate of E		lental Hygie	M 19 10 1	29900
	Physici		1. Decedent's Name (First, Middle, La	st)	7	Rauh		2. Date of Death Month	Day Yeer	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, giv 8506 Akre			4b. City, Town, or	Location of Death	,	10, 2004 4c. County of Death BAH	IMORE
	Funeral Director		5. Social Security Number 6. S 2 (8-53-3268 1  Usual Residence of Decedent	ex 7. Age (In yrs.	last birthday)  5 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye HARCh 6,	ear) "Cgu	place (State or Foreign ntry)  ARY AND
	e Maryland ie-f show lifted at	ctor	10a. State 10b. County		ity, Town or Lo	cation				10d. Inside City Limits 1 Yes 2 □ No
	ath with the 23e or 28 ust by no	rai Director	10e. Street and Number 3531 FAIRNE	out Aven	140	10f. Zip Code 2 1	224	10g.	Citizen of What Cou	ntry?
936	be filed within 72 hours after death with the Maryland that Hygiene.  ed other then "neturel", or Items 23e or 28e-1 show event, the Misteral Exertains must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1   Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of His f Yes, specify Cuban I ☐ Yes 2 XNo		cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: W	etc.
21215-0036	within 72 hou ene. then "neture he Medical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	lent's Usual Occupat kind of work done du DO NOT use retired)	iring most of working	ng	o. Kind of Business/In	,
	ld be filed v ental Hygie ked other t ic event, th	To Be Co	17. Father's Name (First, Middle, Last)  HARRY		DAI	Homem		(First, Middle, Maid	-	NDEL
, Maryland	ges 1 and 2 should be it of Health and Menta if item 27 is marked or other traumatic ev	_	19a. Informant's Nam Relationship (	ARD+ -DAUghter	19b. Mailin	g Address (Street ar	ROAD T	l Route Number, Ci	ity or Town, State, Zip	NBEZ 0 Code) N > 2 12 37 own, State
Baltimore	Pa ant ury		20a. Method of Disposition  1	() GA	20 DEAS	09 H 14	Sent	12 04 R	altimone	HARVION
Ba	permit. Departingorti		21. Signature 15 neral Service Licen	KNEW	22	Joseph 1	OF Facility  Coukling	NINO J St. B.	R. Func.	21224
	Physician /Medical		23a. Part. Enter the disease, dr.com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Acut E  Due to (or as a conseq	StRO		such as cardiar of	r respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. CERGBA  Due to (or as a conseq	eunri	ULM?	Difeene	9		
8760,	cate be executed physician and the burial-transit	ai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseq	uence of):					
9	eath certificate attending phys for use as the	/Medical	IF FEMALE: 23b. Was decedent pregnant	d	ancy				23d. Date of delive	
P.O. Box	that the death ed by the atte detached for	Physician/M	in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	leath 5 🗌	Ectopic pregnancy Other (specify)			Month	Day Year
ords, I	The law requires that the death certificate has been signed by the attending spage 2 should be detached for use as	þ	Part II. Other significent conditions of	ontributing to death but not res	ulting in the un	derlying cause given	in Part I.	23e. Did tobacc	co use contribute to the 2 No 3 Prob	
Vital Records,		Completed						24a. Was an autopsy performed 1 Yes 2 €	prior to cor death?	osy findings available inpletion of cause of
of Vit	Phyelcler this certifical directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	Hospital: 1 Inpatient 2 I	ER/Outpatient	3□ DOA Other:	4   Nursing Hom	ne 5 Residence	6 □Other (Specify	)
Division of	or Attending Phyelclen: after death. Director; After this certific in by the funeral director.	Certification:	1 Aatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury		s 2 No	8d. Describe how in	and Number or Rura	Route Number
Ö	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director, After th completely filled in by the funeral	cal Cert	29a. Certifying Physics	building, etc. (Specify	y)	occurred at the time	date and place, ar	City or Town, Sta	ate)	ated
1	To the H within 24 To the F complete	Medical	29b. Signature and title of certifier	iner: On the basis of examina and manner stated.	tion and/or invi	29c. License r	number	d at the time, date a	and place, and due to  Date signed (Month, L	the cause(s)  Day, Year)
	5		30. Name and address of person who d	and manner stated.  What is a state of the s	1 23a) (Type, P	Print) a	464		9/13/04	
	Sta	te	ROBERT T. U. 31. Date filed (Month, Day, Year)	Banto, M.	3508 ture L	BANKS	T BA	cro, me	12122	7
	Registr	ar	SEP 1	2004 Claure	10	apour				

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registre AMEND ITEM #23a&b PER PHY C835 Colificate of Pleath Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 Year **Physician** SEPT. 9, 11:20 A M OTTO ALBERT RIES, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GLEN BURNIE ANNE ARUNDEL MARINER HEALTH AT NORTH ARUNDEL 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□F APRIL 8, Director 216-07-5911 1919 MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits rthan "natural", or itama 23a or 28a-f show the Modical Expropertional be notified at 1 ☐ Yes 2 X No MARYLAND BALTIMORE COUNTY CHASE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21220 UNITED STATES 1212 STUMPF RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: δ 3 X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER SHIP BUILDING 10 event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fill ment of Health and Mental H sant; if item 27 is marked ott ပ MICHAEL RIES MARIE URBAN traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 DORCHESTER RD., GLEN BURNIE, MD 21060 AGNES E. THOMAS/DAUGHTER other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition SEPT. 10, 1 D Burial 2€X6remation 3 □Removal from State ö permit. Page Department of Important: If any injury or once. 4 □Donation 5 □ Other (Specify) METRO CREMATORY, INC. 2004 CATONSVILLE, MARYLAND 21. Sign aure of Euneral Service Licenses 22. Name and Address of Facility B KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 Approximate Interval Between HOURS Death Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ peq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe certificate 1 ☐ Yes 2 XNo Physician: director 25. Was case referred to medical 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 3□ DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Hospital or Attending 1 X Natural 5 Pending Injury 2 🗌 No 1 Tes hours after death. 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 SEPTEMBER 10, 2004 D 40521

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

o

Records,

Vital

o

Registrar's Signature

7845 OAKWOOD RD., GLEN BURNIE, MARYLAND 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHESH OCHANEY, M.D.,

31. Date filed (Month, Day, Year)

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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: if flam 27 is any injury or other trai once.		20a. Method of Dis					Place of Disposemetery, cre	oosition (Na	me of other plac	ce)	Date	20c.	Location -	City or To	own, State
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			30. Name and add	dress of person	on who complet	ted cause o	f death (Ite	m 23a) (Typ	e, Print)							
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Exami		4a. Facility Name (If not institution 11413 Glen Ar	on, give street and number m Road	r)	41	o. City, Town, o Glen A	r Location of De	ath	4c. C	county of Oea Baltir		
Francis		5. Social Security Number	6. Sex 7. A	ge (In yrs. last		Under 1 Year	If Under 24 H	rs. 8. Date of B	irth		thplace (State	or Forei
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fler this certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a b. Due to (or a c. Due to (or a d	sclerot s a consequer s a cons	nce of):  nce of):  nce of):  sy eath 3	topic pregnance ther (specify) _ strying cause grant with the strying caus	y  y  y  yen in Part I.  26. Place of I  her: 4 \( \text{Nursing} \)  rk?   Yes 2 \( \text{No} \)  ime, date and place opinion, death or	23e. Did  1 24a. Wa aut per 1 X Yes  Death (Check only g Home 5 Be 28d. Describe  28f. Location City or T	d tobacco us  Yes 2  as an opsy formed? 2 No  yone) sidence 6 s how injury  (Street and own, State)  te cause(s) as date and 29d. Date	Month  e contribute to the con	Onset and Onset	Year  death?  Unknows availab cause of mber,  (s)

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ORIGINAL

John Bruce Seaman, Sr.    John Bruce Seaman, Sr.   Nancy Sarro / Mother   101 Woods Ave. Gler	BALTIMORE  8. Date of Birth (Month, Day, Year)  March 6, 1965  10d. Inside City Limits  1 □ Yes 2 ☑ No  10g. Citizen of What Country?  United States  14. Race - American Indian, Black, White, etc.  Specify: White
Director  216-66-4473  Usual Residence of Decedent  1 ☑ M 2 ☐ F 39  Yrs. Months Days Hours	Min. (Month, Day, Year)  March 6, 1965 Maryland  10d. Inside City Limits 1 □ Yes 2 ☑ No  10g. Citizen of What Country?  United States  in? (Specify Yes or No-Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White  16b. Kind of Business/Industry  Plumbing  r's Name (First, Middle, Maiden Sumame)  cy May Brown  r or Rural Route Number, City or Town, State, Zip Code)  n Burnie, Maryland 21061
To the state of th	1 □ Yes 2 ☑ No  10g. Citizen of What Country?  United States  14. Race - American Indian, Black, White, etc.  Specify: White  of working  16b. Kind of Business/Industry  Plumbing  r's Name (First, Middle, Maiden Sumarne)  Cy May Brown  r or Rural Route Number, City or Town, State, Zip Code)  n Burnie, Maryland 21061
Nancy Sarro / Mother  101 Woods Ave. Gler  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Burnie, Maryland 21061
20b. Place of Disposition (Name of cemetery, crematory or other place)  Bayview Crematory  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  1328 Sulphur Spr  238 Sulphur Spr  248 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as c	9/13/2004 Baltimore, Maryland Ambrose Funeral Home, Inc. ring Rd. Baltimore, Maryland 212
Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Sequentially list conditions from the farm of th	Interval Between Onset and Death
in the past 12 months?    Section	23d. Date of delivery Month Day Year
	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
The law also has by page 2 s page 2 s page 2 s page 2 s page 2 s page 2 s page 2 s page 2 s page 2 s page 3	24a. Was an autopsy performed? 1  Yes 2 No  24b. Were autopsy findings available prior to completion of cause of death? 1  Yes 2 No  2 No  30
27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury  28b. Time of Work?  27. Wanner of Death  28b. Time of Work?  27. Work?	rsing Home 5 Residence 6 Other (Specify) AT SCEN 28d. Describe how injury occurred
s a side by si	28f. Location (Street and Scot Talifondson Av. City or Town, State)  Catonsville, Md
TOURK AT FIGURE  29a. Certifier  (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and and manner stated.	
Josha Heanhey Mo  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	29d. Date signed (Month, Day, Year) SEPT. 7, 2004
State Registrar  SEP 1 3 2004  Tasha Z Greenberg M.D. 1111 Penn Street, Balting State Registrar's Signature  SEP 1 3 2004  April 111 Penn Street, Balting State Registrar's Signature	imore, Maryland 21201

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ORIGINAL

			1 - For State Registrar	State of	Marylar	•	artmen rtificate			and M		Reg. N	00	And the second	280	105
ı	Physic		1. Decedent's Name (First, Middle, Last Carl H. Schwalie	-,							2. Date of D Month Septemb	D	ay 7	Year 2004	3. Time 202 /	
	/Medi Examir		4a. Facility Name (If not institution, give St. Agmes Hospita	/	er)		Ba	14im					c. Cour n/a	nty of Death		
	Funeral Director		220-24-30/3	9x 7. ☑ M 2□ F	Age (In yrs. 75	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D 9/5/19	lirth Da <i>y, Year</i> 929	r)	9. Birthp Coun Mary	try)	or Foreign
	within 72 hours after death with the Maryland ene. than "natural; or itema 23s or 28s-f show the Medical Evantrier must be notified at	Director	Usual Residence of Decedent  10a. State 10b. County  MD Baltimor	e		y, Town or La										City Limits s 2⊠No
	vith th	Dire	10e. Street and Number				10f. Zip							of What Coun	•	
	a 23g	E a	5134 Westland Bl	Vd • 12. Was Decede	nt Ever in II	S 13		227	spanic Ori	nin? /Sn	ecify Yes or N			State:		
39	urs after de ai', or item manicari	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Force 1 XYes 2 If Yes, Give Year or Date	ss? □No 194	45-	If Yes, spec	ify Cuba	Specify:	, Puerto	Rican, etc.)	.0-	В	lack, White,	etc.	
21215-0036	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any njury or other traumatic event, the Medical Examinat must be notified at once.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4		16a. Dece	dent's Usua kind of woi DO NOT us	k done d	turing mos	t of work	ing	16b.	Kind of	Business/Ind	dustry	
	ygien ygien yer th	Con	12			Inspe	ector							ties		
and	tal H ad off	Be	17. Father's Name (First, Middle, Last)								First, Middle			ame)		
ž	hould id Mei mark matic	ို	Anton Schwalier  19a. Informant's Name/Relationship (1)	Type, Print)		19b. Mailir	na Address	(Street a			th Sch			n State Zin	Code)	
Maryland	nd 2 salth an 27 ts i		Pat Corbett / day		-law						larksv					
Jre,	of Hea		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of	- 1		Date	-		n - City or To		
Ē	Page ment g ant: if		1 ☐ Burial 2 ▼Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	<i>'</i> )	Ba	yview (	Cremat	tory		9/9/	2004	Ва	lti	more,	Mary1	and
Baltimore,	permit Depart Import any inj	(	21. Signatu 1 Funeral Service Licen	DOUN	JU	2XI	2. Name an 328 St			All	brose Rd. B			-		
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on eac	h line.	h. Do not ent Imfa	•		g, such as	cardiac (	or respiratory	arrest,			Approximation of the Approxima	etween d Death
	/Medical Examiner		resulting in death)  Sequentially list conditions,	Ventri	as a conseq cular	uence of):			,						House	Ś
	ocuted nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Small		0 1	bstru	chor	n						bays	ŝ
8760,	cate be executed physician and the burial-transit	dlcal Ex	resulting in death) Last		as a conseq Europe	uence of):	of C	irtic	al -	Illm	1522			1	Month	S
.O. Box 6	rath certifi attending for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnan 9 Unknown	2 ☐ Feta t at time of d	Ideath 3	Ectopic pro							Date of delive	ry Day	Year
S, D	w requires that the de been signed by the should be detached	ed by PI	Part II. Dther significant conditions of Abdominal Aneurysin		h but not res Nic Colo	- 1	nderlying ca					tobacco ] Yes 2		ntribute to th 3 ☐ Proba		death? Junknown
Record	: The law recate has bee page 2 sho	Completed by	Tracheostomy, Recta	and the same of the	Leale	Riph	0.7	No.	lar Bi	VIII.		s an opsy formed/ 2 N		. Were autop prior to con death? 1 \(\sum \text{Yes}\)	sy findings	s available cause of
ta		Bec	25. Was case referred to medical	neuropui	119-i-	oroncir	9 711	ry			Check only			100		
× >	Phyaician: r this certific ral director,	ပ္	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 Inp.		ER/Outpatier			4 🗆 140		me 5 🗆 Res				)	
UC C	ling P	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	f 2	Bc. Injury Work	at ? Yes 2□!	- 1	28d. Describe	how inju	iry occi	urred		
Division of Vital	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	Injury - At he etc. (Specif	ome, farm, str					28f. Location City or To			nber or Rural	Route Nu	mber,
	ospital hours uneral ly filled	edical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be liner: On the basi and manner	s of examina	wledge, death tion and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deal	d place, th occurr	and due to the ed at the time	e cause(s , date an	s) and n	nanner as sta e, and due to	ated. the cause(	(s)
1)	To the H within 24 To the Fi complete	Ā	29b. Signature and title of certifier				29c	. License	number					ed (Month, E		
•	> - 0		1 Separa Lau	msli	1 im	(1)	F	170	008			Sej	HW	nber C	7,20	104
	Op		30. Name and a dress of person who of Sylwia kaipimska	Poleted cause of		_	Print) 207	Buli	himoi	e iv	10 218	129				
	Sta Regist		SEP 13 2004	32. Reg	strar's Signa	ture	Res.	-								

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Registrar

SCHWALIER, CARL

				State of Ma	arylar	•			Mental Hy	/giene	0.1	00000
			AMEND ITEM #8 PER  1. Decedent's Name (First, Middle, Las	<b>FH G835</b> 9	<del>/20/</del>	<del>'04 JII</del>	ificate of	Death	2. Dete of D	Reg. No.	14	3. Time of Death
	Physici		Roland August Scher						Month Septem	ber 8 2004	Year	5:15 am
ذ	/Medio Examir		4e Fecility Name (If not institution, give					4b. City, Town, o	r Location of Dea	th 4c. County	of Death	
			Manor Care Rossville 5. Social Security Number 6. Se	7 40	2 /lo 1/50	last birthday)	If Under 1 Year	Rossville	S R Date of Bi	Baltin	noice_	lans (State or Farsion
	Funeral Director			JM 2□F		Yrs.	Months Days			1 <del>1911</del>	Count Ralti	lace (State or Foreign try) MOre, MD
	70		Usuel Residence of Decedent			h. Tour or land	dia a		July 2	<u>. 1911</u>		
	Aaryla shov	٥	10a. State 10b. County			ty, Town or Loca	ition				16	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the N	rect	Maryland Baltimore  10e. Street end Number		Hyd	es	10f. Zip Code			10g. Citizen of W	/hat Coun	^
	th with	ai Di	12508 Regwood Road				21082			USA		
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U	,S. 13. W	as Decedent of res, specify Cut	Hispanic Origin? ( pen, Mexican, Pue	Specify Yes or Norto Rican, etc.)		- America k, White, e	
120	rs afta	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates:	lo	10	□Yes 2□χNο	Specify:		Specify:	Whi.	to
21215-0020	2 hou atural	ted t	15. Decedent's Edu	ucation		16a. Decede	nt's Usual Occu	pation	a deia a	16b. Kind of Bus		
218	within 7 ene. than 'n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DC	nd of work done NOT use retire	during most of w	o <i>rki</i> n <i>g</i>			
121	filed with Hygiene. other than	S	12 17. Father's Name (First, Middle, Last)	N/A		Machinis	t	18 Mother's No	amo /First Middle	Bethlehen		1 Co.
Maryland	ould be fi Mental I- arked ot	o Be	Roland Scherer					Ida Shir		i, ivialuen sumame	1/	
aryl	2 should and Men is marke	၉	19a. Informant's Name/Relationship (T)	ype, Print)		19b. Mailing	Address (Stree			per, City or Town, S	State, Zip	Code)
	and 2 salth a n 27 is		E. Maryland Pangborn			301.3 Ar	izona Ave	nue Balti	more, Mary	land 21234	ł	
Baltimore,	parmit. Pages 1 and 2 Department of Health e important: if item 27 is any injury or other tra phce.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F	Removal from State	20b. F	Place of Disposit cemetery, crema	ion (Name of tory or other pla	ice)	Date	20c. Location - (	City or Tov	wn, State
Itim	rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify)  21. Siscature of Funeral Service Licens		Mor		orial Par	k Sept. 13	3 2004	Baltimore	Mry.	land
Ba	parmit. Departrimports any infi		21. Statute of Pulleral Service Licens	1 Office	2-1	La	ssahn Fur	meral Home				
	y	$\dashv$	23a. Pert1. Enter the disease, or comp	lications that caused	the deat	h. Do not enter	01 Belair the mode of dyi	Road Balt ng, such es cardia	imore, Mai ac or respiratory a	ryland 2123 urrest,	1	Approximate
The same	Physician		shock, or heart failure. List only o	ne cause on eech lin	Θ.						1	Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	00	40	AITU					j	1 YR_
П	Examine	- L	resulting in death)		Due to (d	or as a conseque	ence of):				1	
	uted d ansit	Examiner	Sequentia the list conditions	b	Due to (o	r as a conseque	ince of):			·		
0	tificate ba axecuted g physician and as the bunal-transit	Exa	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	·	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	. 40 4 50.10040					1	
68760,	ohysic the bi	edicai	that initiated events resulting in death) Lest	c	Due to (o	r as a conseque	nce of):					
	aath certifi attanding for use as		L.	d								
. Box	law requires that the daath certificate ba axecuted as been signed by the attanding physician and as Should be detached for use as the bunal-transit	Physician/M	Part II. Other significant conditions con	ntributing to death bu	t not res	ulting in the und	erlving cause gi	ven in Part I.	23b. Did	tobacco use cont	tribute to	the cause of death?
P.0	that tha dat ned by the a detached f	Phys	HYPERG GUILO				, g-					ably 4 🗆 Unknown
	w requires that been signed t should be det	ρ									045 146-	ire autopsy findings
Š	been	etec							24a. was	an autopsy prmed?	ava	illable prior to npletion of cause
Records,	8 - 0	Completed							14(5)	Yas 34 No		leath?
tal	ician: Thi certificata rector, pag	Be	25. Was case referred to medical					26. Place of De	eath (Check only			1103 2 1100
of Vital	5 00	To E	examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatier	nt 2 🗆	ER/Outpetient	3□ DOA Oti	ner: 4 Nursing	Home 5□Resi	dence 6 □Other	r (Specify,	ý
	ing Pth		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	28c. tnju Wo M 1	ryet rk?  Yes 2 □ No	28d. Describe	how injury occurre	d	
Division	or Attending I aftar daath. Director: After I in by tha funer	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Plece of Inju	ry - At ho	ome, farm, stree		162 Z NO	28f. Location (	Street and Number	r or Rural	Route Number,
<u>S</u>	al or a saftar	Certification:	4 Homicide	building, efc					City or To	wn, State)		
1	lospitu I hours uners	edical		sician: To the best of ner: On the basis of								
1	To the Hospital or Attending Ph within 24 hours after daath.  To the Funeral Director: After th complately filled in by the funeral		one)  29b. Signature and title of certifier	and manner ste			29c. Licens			29d. Date signed		
	P × P O		· · · · · · · · · · · · · · · · · · ·	10				17945	-	SED 8	. 7	(V) M
		-	30. Neme and eddress of person who co		eth (Item	1 23a) (Type, Pri		17-147		> 0- 0	>	V 1
	124		HARU ALEEM	( am	505	OSCO		ETOW	>670 V	up 212	04	
	Sta		31. Dete filed (Month, Day, Year) SEP 1 3 2004	32/Registre	r's Signa	ture doss	<i>M</i> ,					
	Registr	al a	25 - A 700.	THE PROPERTY OF		- ANDES						

DHMH 16 Rev 6/95

		Please	State of Manua				-	_	ile.
		1 _ State	State of Maryla		ertificate of		_	000	1 00007
		Registrar  1. Decedent's Name (First, Middle, Las			eruncate of	Dealli	2. Date of De	Reg. No.	3. Time of Death
Phys /Me	ician dical	01 101	TSON SE	5			AUGUST	Day 2	206 PM
Exan	niner	4a. Facility Name (If not institution, give		- 1\ A-		or Location of Deat		4c. County of	A.,
	-1	5. Social Security Number 6. S		rs. last birthday		HAVRE de	8 Date of Bir	th	9. Birthplace (State or Foreign
Funer Directe			XM 2□F 45	Yrs.	Months Days	Hours Min.	02/28	v. Year)	Maryland
yland		10a. State 10b. County	10c.	City, Town or I	_ocation				10d. Inside City Limits
e Mar 3e-fa	cto	MD Harford		Belcam	)				1X Yes 2 □ No
vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	nat Country?
eath v	Funeral	4429 Perkins Plac	e 12. Was Decedent Ever in	115 13	21017 . Was Decedent of		necify Ves or No	USA 14 Bace	- American Indian,
fter d	F	11. Marital Status 1 ★ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No	10.0.	If Yes, specify Cub	oan, Mexican, Puer	to Rican, etc.)		, White, etc.
O3C	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2X No	Specify:		Specify:	White
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 Is marked other than "natural", or Items 23e or 28e-f ahow traumatic event. The Medical Examinat must be notilied at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dec (Giv	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of wo	rking	16b. Kind of Bus	iness/Industry
Vithin within sine.	E D	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		sabled	90)			
d 2 filed Hygie other	ပိ	17. Father's Name (First, Middle, Last)			Sabied	18. Mother's Nar	me (First, Middle	, Maiden Sumame	))
ld be lental ked c	To Be	Unknown				Gladys	See		
ary shou	[	19a, Informant's Name/Relationship (	Гуре, Print)	19b. Mai	ling Address (Street	AND THE PERSON NAMED IN COLUMN		er, City or Town, S	itate, Zip Code)
and 2 ealth m 27 I		Gladys See- Moth							re de Grace
Baltimore, Dermit. Pages 1 ar Department of Hea Important: If Item any injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3	Memoral IIOIII State		position (Name of ematory or other pla		Date		City or Town, State
timen rtant:		`4 □Donation 5 □Other (Specify	() R		rris & Co				ester, PA
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Hem 27 is marked other than "natural", or Items 23e or 28e-1 ahow any injury or other traumatic event. The Medical Examinat must be notified at	Suce	21. Signature of Funeral Service Licen	Son He	) N	Name and Address	mithFun	eral Hon	ne, P.A.	- MD 21079
WINDS STREET		23a art1. Enter the disease, or com-	plications that caused the de						e, MD 21078 Approximate
Physicia		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	- D-	P in D	ti	)		Interval Between Onset and Death
/Medic	al	disease or condition resulting in death)	Due to (or as a cons	sequence of):	inga	ndiava	*	Λ-	
Examin		Sequentially list conditions	. allinos	cler	tic Ca	ndiava	scrolan	) dises	d
sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se a none	equalica ot):					
60, be executed ician and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):					
760, te be executed ysician and te burial-transit	caiE		,						
Records, P.O. Box 687  The law requires that the death certificate the has been signed by the attending physage 2 should be detached for use as the	edic		, d.					- 1	
Box eath cert attendin for use	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1□Live birth 2□Fe		□Ectopic pregnanc	cv			of delivery
O. B. the deat y the att	sicis	in the past 12 months? 1 □ Yes 2 No	4☐Pregnant at time o		Other (specify)	-7		Mon	th Day Year
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dS, irres ti signe d be c		Fatti. Other significant conditions of	onthibuting to death but not i	asumg in me	dildeliyilig cause gi	WOITHIT GILL.	1 🗆	,	B □ Probably 4 □Unknown
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Re(he lav	Completed						autor perfo	osy pr ormed? de	ior to completion of cause of eath?
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d is X	ToB	examiner? 1 X Yes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpation	ent 3 DOA	hor	lome 5 ☐ Resi	929	(Specify) MOTHERS
On O ding Ph h. After th funeral	ü	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury		ry at ork?	28d. Describe	how injury occurre	d Itoyse
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Division or Attendated after death Director: in by the	Ħ	4 Homicide determined		t home, famn, s ecify)	street, factory, office		City or To		r or Rural Route Number,
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	S C	29a. Certifier 1 ☐ Certifying Ph	ysicien: To the best of my k	mowledge, dea	ath occurred at the t	ime, date and place	and due to the	cause(s) and man	ner as stated.
ne Hos 24 h ne Fur	edical	(Check only 2 Medical Examone)	niner: On the basis of exami and manner stated.	ination and/or	nvestigation, in my	opinion, death occu	urred at the time,	date and place, ar	nd due to the cause(s)
To the within 2 To the complet	M	29b. Signature and title of certifier	10 44 0		29c. Licen	se number		29d. Date signed	(Month, Day, Year)
//		Demant & Ke	Kem MU, Ill	1/2	DCO.	14206	5	Sept 1,	2004
1,0		30 Name and address of person who	completed cause of death (II	12 (Type	Print)	MARIA	a dia	Du (T	Md 21722
.2	State	31. Date filed (Month, Day, Year)	32. Registar's Sig	gnature L	1010 11	NOW	m rive	BNAIC	> 1700 X122
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 SEPT. Physician MYRTLE MAE SINGLETON 12, 7:30 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ANNE ARUNDEL GLEN BURNIE MARINER HEALTH OF GLEN BURNIE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🔀 F 103 496-32-3565 Yrs. 15, 1900 ILLINOIS **Director** Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d, Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21060 UNITED STATES 7849 SHELLYE RD. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: þ WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. HOMEMAKER OWN HOME other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ith and Mental h Be (UNKNOWN) (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Importent: If item 27 Is
any injury or other trau 7849 SHELLYE RD., GLEN BURNIE, MARYLAND 21060 BONITA M. DURRELL / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) SEPT. 2004 20c. Location - City or Town, State 20a. Method of Disposition 15 BROOKLYN PK., MARYLAND 21. Signature of Fune al Service densee 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A.
421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IN FA ACTION MYUCARDIAL Physician ACUTE /Medical Due to (or as a consequence of): Examiner ARTEMOSCLEROTIC CARDIOVAS CULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine DIJEAST that the death certificate be executed and I-tran Due to (or as a consequence of): physician a Box 68760. Physician/Medical as esn IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) Ö the 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by OSTEO ANTHRIMS 1 Yes 2 No 3 Probably 4 Unknown been si Completed DEMEN 1700 24b. Were autopsy findings available prior to completion of cause of death? SENILE 24a. Was an page performed? Yes 2€ No certificate l 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No P HIS 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and titlé of certifier 29c. License number 29d. Date signed (Month, Day, Year) anni mo D 17753 SEPTEMBER 13, 2004 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARUP DHARMASENA, M.D., 710 CHURCH RD., BALTIMORE, MARYLAND 21225 31. Date filed (Month, Day, Year) **SEP 1 3 2004** 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** September 10 2004 9:20 A.M Margaret 0. Sowers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Millennium Health & Rehab. Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 17, 19 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🕱 F Mary land Director 215 58 3337 Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10a State 10b. County 10d. Inside City Limits rel', or items 23a or 28a-f show Exemples must be notified at 1 Yes 2 No Maryland Anne Arundel Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 206 Haile Avenue 21225 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Intercrant: if item 27 is marked other then "naturel", or itel any nijury or other treumetic event. Ite Medical Exercit en any sonce. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: þ 3 XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Byers Margaret A. Spilman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Sowers son 206 Haile Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 9/15/2004 Elkridge, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee . 4001 Ritchie Highway Baltimore, Maryland 21225 23a. 5 rt1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Lind only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ENSION requires that the death certificate be executed anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No Live birth 2 Fetal death 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 🗆 Unknown been signed by i should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Oeath (Check only one) Be Other: 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Unursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? f Death 28b. Time of 28d. Describe how injury occurred 27. Mann Injury 1 Vatural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral I
completely filled 29a. Certifier to the cause (s) and manner as stated. Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature athifton 83a) (Ty State (O A FIT TMUPE, MARYLAN 32. Registrar s Gignatur 31. Date filed (Month, Day, Year) State

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Registra

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			- State Registramend ITEM #1 PER ME G8  1. Decedent's Name (First, Middle, Last)	35 9/46/	turcase of Death	Reg. 2. Date of Death	. No.	3. Time of Death
	Physici		Cynthia Ann S	Scarboro	ough	Month September	Day Year 2004	22:25 M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	1	4c. County of Death	
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	Funeral Director		218 90 3343 1□M 2ÅF 42	rs. last birthday) Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, You Sept. 3,	1962 Mar	place (State or Foreign http: yland
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c.	City, Town or Lo	cation		1	0d. Inside City Limits
	a-f sh	ctor	Maryland Anne Arundel	Baltimo	re			1 ∐Yes 2 <b>∑</b> No
	or 28	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cour	ntry?
	s 23a	erai	316 – 14th Avenue  11. Marital Status 12. Was Decedent Ever in	118 13 1	21225 Vas Decedent of Hispanic Origin? (Sp	acifu Van or No	U.S.	ean Indian
2-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Marical Examinational bandling at	Completed by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	t	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, Specify: Whi	etc.
2	within 72 ho ene. than "natur ne Musical	npieted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	lent's Usual Occupation kind of work done during most of work OO NOT use retired)	ing	b. Kind of Business/In	·
2	filed with Hygiene. Ither than		12th 17. Father's Name (First, Middle, Last)	House	keeping/Nursing A	SSIStant e (First, Middle, Mai		irsing Home
Maryland	should be fi and Mental H s marked of umatic ever	To Be	Frank Rainey Jr.			a Lee Pay	,	
Mary	and 2 sho lealth and I m 27 Is me her traums		19a. Informant's Name/Relationship (Type, Print) Frank Rainey Jr./ Father		g Address (Street and Number or Run - 14th Avenue		ity or Town, State, Zip. Maryland	
Baltimore,	8 = 5		1 XBurial 2 Cremation 3 DRemoval from State	o. Place of Dispo- cemetery, cren		Date 200	c. Location - City or To	own, State
Baltin	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licensee	1 22		nce Funer	cal Service	
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.O. Box 68	death certii e attending id for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of pregnant at time of pregnant at time of pregnant at time of polymers.	etal death 3 [	Ectopic pregnancy		23d. Date of delive	ory Day Year
<u>α</u>	w requires that the been signed by th should be detache	ed by Pi	Part II. Other eignificant conditions contributing to death but not reconstructions.	resulting in the ur	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the	
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Division	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - Al building, etc. (Spe		eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	e Hospil 24 hour e Funera letely fille	edical (	29a. Certifier (Cherk only one)  1 Certifying Physicien: To the best of my keep control of the basis of examinand manner stated.					
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month,	Day, Year)
			1 ( lorkem)		O.C.M.E.	Se	eptember 08	, 2004
-	<b>n</b>		30. Name and address of person who completed cause of death (I	1	11 Penn Street, E	Baltimore,	Maryland	21201
••	Sta Regist		31. Date filed (Month, Day, Year) 3. Registrar's Sig	mature of	note			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2004 Richard Arthur Seibel /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ROSEDALE
If Under 1 Year If Under 24 Hrs. DALTIMORE HOSPITAL SQUARE FRANKLIN 8. Date of Birth (Month, Day, Aug 6, Birthplace (State or Foreign Country)
 MA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Hours 64 Yrs. 015-30-4751 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic svent, Ite Marked Examines must be notified as 1 ☐ Yes 2 No Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 United States 803 Arncliffe Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 242No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify. White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) State of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Counselor SEIBEL, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Antionette Maria Pooler Chester Joseph Seibel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Virginia Seibel/Wife 803 Arncliffe Road, Baltimore, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Sep 10 1 □ Burial 2 Deremation 3 □ Removal from State Beltsville, MD 2004 Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYOCARDIAL Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CoRonary AR ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transit COPD and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 028762 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 SQUARE DR. BALTIMORE MD 21237 FRANKLIN AHUJA DR. SUNIL 2. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 3 2004 Registrar

			State of Maryla		irtment of h tificate of			giene Reg. No. 1	11. 28	2012
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an age	Physician /Medical	margaret C. Spit				4b. City, Town, or	Month Septem	bor 8	of Death	0530
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				s. last birthday)	If Undar 1 Yaar	If Undar 24 Hrs			9. Birthplaca (S	State or Foraign
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Maryland 21215-0020 ON HOLD AND ADDRESS TO SHOULD BE filed within 72 hours after deeth with the Maryland	of, or items 23s or 28s-f show Examiner must be notified at by Funeral Director		12. Was Dacedant Evar in I Armed Forcas? 1 ☐ Yes ②No If Yes, Giva Yaar or Datas:		Nas Decedant of I f Yas, specify Cub I ☐ Yes 2 No	Hispanic Origin? (S an, Mexican, Puar Specify:	spacify Yas or No to Rican, etc.)		e - American Ind ck, Whita, etc. /: White	iaii,
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Aaryla 2 should	end la me ls me	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	g Address (Straat	and Number or R	u <b>ra</b> l Route Numb	ar, City or Town,	State, Zip Code)	
≥ ; bue	Heelth am 27 ther tr	Richard Spittel/		_		gh Dr., A				
- 40	0	20a. Method of Disposition 1 ☐ Burial 2/ ☐ Cremation 3 [		Place of Dispo cemetery, cren	sition (Name of natory or other pla	ce)	Sep 9	20c. Location -	City or Town, St	ata
rimo Paga	man ant: ury	4 □ Donation 5 □ Other (Speci			ke Crema		2004	Beltsvi	ille, MD	
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d. 1	nysician Medical xaminer	Immediata Causa (Final diseasa or condition rasulting in daath)	a. <u>END STAGE</u> Due to	E MU		SCLEROS	is		11	LONIN
uted	D Sign		b. Due to	or as a conseq	neuce of).				1	
D, exec	in and halfm	Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Causa (Disaasa or injury	240 10	(01 00 0 0011004	201100 01)1				1	
. BOX 68760, daath certificata be executed	physician and s the bunal-trensit	Causa (Disaasa or injury that initiated avants resulting in daath) Last	cDua to (	or as a conseq	uance of):					
		Lossing in duality 2250								
BOX aath cert	tendi or usi		0.			-				
tha daa	d by the attending patached for usa as Physician/Me	Part II. Other aignificant conditions	contributing to death but not ra	sulting in the ur	ndarlying cause gi	ven in Part I.	23b. Did	tobacco usa co	ntribute to tha c	ausa of death?
F F	igned by the attending I be datached for usa as by Physician/Me						1 🗆	Yes 2□ No	3 Probably	4 🗗 Onknown
VITAL HECOPOS, P	ate has been signe, paga 2 should be o							an autopsy med?		prior to on of cause
	has ga 2								of death?	
<u>a</u> =	cartificate he rector, paga		1			00 Di(D-	101		1 ☐ Yes	280 140
OT VITA Physician:	cartific irector	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	TED/Outpation	t 3 DOA Ot	hor:	ath <i>(Check only c</i> Homa 5□ Resid	4.7.47	or (Specify)	
o Ę	rthis care directions.	27. Mannar of Death	28a. Data of Injury	☐ ER/Outpation 28b. Tima of	1-1-1			now injury occur		
	th. : After a fune	1 Maturat 5 ☐ Panding 2 ☐ Accidant investigation	(Month, Dey Yaar)	Injury		nk? ]Yes 2∐No				
DIVISION at or Attanding	5 t t	3 Suicida 6 Could not a determinad		homa, farm, str	aat, factory, office		28f. Location (S City or Tox		er or Rural Route	e Numbar,
Hospita	within 24 hours at To the Funeral D completaly filled i	29a. Cartifier (Check only one)  1. Certifying Physician: To the best of my knowledge, daath occurred at the time, data and pla control of the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and pla control of the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and pla control of the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and pla control of the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and pla control of the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and pla control of the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and pla control of the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and pla control of the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and pla control of the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and pla control of the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and pla control of the basis of examination and occurred at the time, data and pla control of the basis of the						cause(s) and ma date and place,	inner as stetad. and due to the ca	ause(s)
To th	Within To the comp	29b. Signatura and titla of certiliar 29c. Licensa number						29d. Data signa	(Month, Day, Y	'ear)
	)	I relloyah &	seul		H43	931		Septor	nbor8,	2004
	O	30. Name and address of person who	completed causa of death (Ite	om 23e) (Type,	Print) 2K HE1611	TS AVE 1	BACTIMI			
	State	31. Dete filed (Month Paya Year) 20	04 Registrar's Sign	dera Apo	de					

		1 - State Ragistrar	of Maryland / [		tificate of I		•	Reg. No.	INL	28913
Physici		1. Decedent's Name (First, Middle, Last) Pauline G. Treptow					2. Date of Dea	Day	Year	3. Time of Death
/Medio		4a. Facility Name (If not institution, give street and no	umber)		4b. City, Town, or	Location of Death			unty of Dea	
		Greater Baltimore Medic	al Center		Towson			В	altimo	re
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. last bii 87	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da December	, 16, 19	9. Bin 16 Mar	hplace (State or Fore punity) y land
ied at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore	10c. City, Tow Balt	m or Lo	cation	,				10d. Inside City Lin
3a or 28s	I Direc	10e. Street and Number 2205 K Falls Gable Lane			10f. Zip Code 21209			10g. Citizer	n of What Co	ountry?
Department of Health and Mental Hygiane. Important: If item 27 is marked other than "natural", or itema 23e or 28e f ahow any injury or other traumatic avent, the Medical Eval. if are must be notified at another.	by Funeral Director	11. Marital Status 12. Was De Armed F	2 XNo		Vas Decedent of H	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No-	14.		•
n natur	Completed by	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0·12) College	16a.	. Deced (Give	lent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work f)	king	16b. Kind	of Business	Industry
r tha	mo	12 N/	(1-4or 5+) A E]6	ectro	onics			Indus	trial	
fental Hygrkad otheric avent,	To Be C	17. Father's Name (First, Middle, Last) E.J. Gilpin, Jr.				18. Mother's Nam Lillian St		Maiden Su	mame)	
alth and h		19a. Informant's Name/Relationship (Type, Print) Gregory L. Logsdön/Son			g Address (Street a Sherwood A					Zip Code)
ant of Heart: If Item y or othe	1	20a. Method of Disposition  1 Disposition  2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	State cemete	гу, сгеп	sition (Name of natory or other plac Redeemer	9/13/	Date 104 F		ion - City or re Mary	Town, State
Dapartme importar any injur once.	li		stina L. Hilto	on 22	Name and Address	s of Facility				Turiu
		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do		305 Harford		timore Mar		21214	Approximate
ysician Medical	i q	shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	each line.							Onset and Deat
aminer	r e	Due to	o (or as a consequence	cler	2.00					J
ysician and ne burial-transit	icai Examiner	Sequentially list conditions, in your landing to mead the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to the cause of the condition of the cause of the c	(or as a consequence	of):						
by the attending physi tached for use as the l	Physician/Medic	in the past 12 months?	utcome of pregnancy birth 2 Tetal death gnant at time of death nown		Ectopic pregnancy Other (specify)		753/50 A A	23d	. Date of del Month	ivery Day Year
should be detac	by	Part II. Other significant conditions contributing to	1	n the un	nderlying cause give	en in Part I.	23e. Did to	7		the cause of death
nis certificate has bee I director, paga 2 shoi	Completed							sy mod? 2 No	prior to death?	topsy findings avail completion of cause 2 ☐ No
After thunara	ation; To Be	27. Manner of Death 28a. Date	of Injury 28b. 1	utpatient Time of Injury	28c. Injury Work	at	h (Check only or ome 5 Resid 28d. Describe h	ence 6		afy)
24 nours anar deam • Funeral Diractor: A stely filled in by the f	Certification;	3 Suicide 6 Could not be determined built	e of Injury - At home, fa ding, etc. (Specify)	arm, stre	eet, factory, office		28f. Location (S City or Tow	treet and N n. State)	umber or Ru	ral Route Number,
meri / fills	Medical (	29a. Certifier (Check only one) Certifying Physician: To the 2 Medical Examiner: On the and ma	e best of my knowledge basis of examination an nner stated.	e, death nd/or inv	occurred at the time estigation, in my op	ne, date and place, pinion, death occur	and due to the c red at the time, c	ause(s) and late and pla	d manner as ce, and due	stated. to the cause(s)
n 24 i ne Fu oletely	~	29b. Signature and title of certifier			29c. License				gned (Month	n, Day, Year)
within 24 hours atta To the Funeral Dir completely filled in		11 0 0					1	F 1 F		
within 24 I		30. Name and address of person who completed cat  45 69 N Cha les			02	0907		9/10/	104	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 7: CYPM 09 Georgia Elizabeth Voland 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1□M XXF 61 Sep. 10, 1942 Maryland Director 212-44-6949 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location. 10a, State 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore Arbutus MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5203 Carroll Place 21227 United States Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or Itel any injury or other traumatic event. Its Medical Exemina 1 XX Sever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo White Specify: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Katherine L. Horner 0 Vernon E. Voland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5203 Carroll Place, Arbutus, MD 21227 Katherine L. Voland Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 9-13-2004 \* 4 □ Donation 5 □ Other (Specify) Western Cemetery Baltimore, MD 22. Name and Address of FacilityAmbrose Funeral Home, Inc. 21. Sign ture of Funeral S 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No o 9☐ Unknown 9 Unknown Š Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No rebrovascula 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 H10 or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death After 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after within 24 hours a To the Funeral C completely filled 1 Decrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sept 10, 2004 D57531 , ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Of a Veterans Hwy nullersville 2 Registrar's Signature 31. Date filed (Manth, Bay) Year) 2004 State Registrar

			1 - State Registrar	partment of Health and Me ertificate of Death	ental Hygiene	and the second of the second o
	Physici	an	1. Decedent's Name (First, Middle, Last)  Thomas R. Wright		2. Date of Death Month Day	
	/Media	cal	Thomas R. Wright  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
	Examir	ier	Stella Maris @ Mercy Hospital	Baltimore City	40.	N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Days Hours Min	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign     Country)
	Director		213-26-6352	Northis Bays Tiours Will.	Feb. 9,193	30 Maryland
	land ow		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Many a-fah	tor	Maryland Baltimore	Dundalk		1 ☐ Yes <b>2</b> ⁄☐ No
	or 28	by Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citiz	zen of What Country?
	s 23a	ral	8116 North Boundary Road	21222		ted States
	Itams Itams	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	<ol><li>Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R</li></ol>	cify Yes or No-	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
036	urs af		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🕱 No Specify:		Specify: White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 ahow ita Madical Examinar must ba natified at	Completed		cedent's Usual Occupation ive kind of work done during most of work done	16b. Kir	nd of Business/Industry
2	han "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	a. DO NOT use retired)		
2	Hygie thar t		2 Years T	raffic Manager	(First, Middle, Maiden	ied Chemical
Maryland	d be f ental h ked of	To Be	Roy Thomas Wright		ıise Dulin	Sumame)
ary	shound M	-		tiling Address (Street and Number or Rural	Route Number, City or	Town, State, Zip Code)
Σ	and 2 salth a n 27 ls			6 North Boundary Roa		, Maryland 21222
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or Itams 23a or 28a-1 ahow any injury or other traumatic event, II is Marical Examiner must be neitiled at once.		1 Burial 2 □ Cremation 3 □ Removal from State cemetery, of	position (Name of rematory or other place)  Valley Mem Park 9/1	1.00	cation - City or Town, State
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee / Houtsul , I	22. Name and Address of Facility Duda-Ruck Funeral Ho 7922 Wise Ave. Dund	ome of Dund	lalk,Inc. and 21222
			23a. Part1. Enter the disease, or complications that caused the eath. Do not shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	tul concer		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			
	10	- F	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
VI.	cuted od ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cisassa or in uy that initiated events cause in initiated events could be a consequence of cause Cisassa or in uy that initiated events cause in initiated events c			
ő,	be executed sician and burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):			
8760,	cate b	dlcal	d			
9 x	death certific attending pl	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			24 Day 44 F
Box	death e atter d for L	iciar	1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Vas 2 ☐ No. 4 ☐ Pregnant at time of death	B Ectopic pregnancy C Other (specify)		3d. Date of delivery  Month Day Year
P.0	that the de led by the detached	hys	9 □ Unknown			
S, F	90	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		se contribute to the cause of death?
oro,	w require been sig should b	eted			1 ☐ Yes 2	No 3 Probably 4 Unknown
of Vital Record	hast pe 2 s	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
īa	ician: The l certificate ha ector, page :	e Co	25. Was case referred to medical		1 ☐ Yes 2 No	1 Yes 2 No
<u>=</u>	Physician: this certificaral director, p	0 8	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpat	26. Place of Death ( ent 3□ DOA Other: 4□ Nursing Home		Sother (Specify) Hospice
	on 0 0	-	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28	3d. Describe how injury	1100,100
Sio	Attanding ir death. ector: After by the fune	atlc	2 Accident investigation	M 1 Yes 2 No		
Division	F SF F	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28	3f. Location (Street and City or Town, State)	Number or Rural Route Number,
	spital ours a naral I		29a. Certifier Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, as	ad duo to the course(s) a	
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred	d at the time, date and p	place, and due to the cause(s)
	To the A within 24 To the B complete	Ž	29b. Signature and title of certifier	29c. License number		signed (Month, Day, Year)
			) Du Im m	040854		4 110 120 04
	D		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print) St. Paul Pl	Baltin	1202
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature			<u> </u>
	Registr	ar	SEP 1 3 2004 Deneva	& Sparker		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** Year Macie Walker 6:20 A M /Medical September 8,2004 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Baltimore 2548 N. Snyder Avenue Edgemere 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2FXF Yrs Director 234-56-2185 Aug. 23,1923 West Virginia Usuel Residence of Deceden death with the Maryland works 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or Iteme 23a or 28a-f shov the Medical Examinar must be notified at 1 Yes 2 XNo Maryland Baltimore Direct Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2548 North Snyder Avenue 21219 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. nours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: \$ Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If item 27 is marked other than any Injury or other treumatic avant Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Van Browning Bessie Browning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Grimmett / Niece P.O. Box 537 Davin, West Virginia 25617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 9/11/2004 Baltimore, Maryland 21. Sign Hure of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 23a Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancreatic Cuncer Priysician < cms) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Y ear 5 Other (specify) Records, P.O. the detached à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy Division of Vital 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of After Certification: 28d. Describe how injury occurred Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Tpletely (Check only 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 039460 W(F 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Builtimore Mi) Robert Dourt True worth 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

3 2004

SEP1

	_	State of Maryland / Department of Health and Me  Certificate of Death	ntal Hy	•	28917
Physiciar			Date of De Month	Day Yea	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	POTEMI	4c. County of De	
		Stella Maris at Mercy Hospital Baltimore		N/	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Yrs. 81 Yrs. 81 Yrs. 1 Months Days Hours Min. 1	. Date of Birt (Month, Da	th 9. E	hirthplace (State or Foreign Country)
g	- 1	Usual Residence of Decedent	0/19/1	1922   Mai	ryland
And the Maryland death with the Maryland ma 23a or 28a-1 show the modified at	5	Maryland N/A Baltimore			10d. Inside City Limits 1 1 Yes 2 □ No
Man'e  036  urs after death with the Ma ali, or terns 23a or 28a-1 s  Examination sust be multilish by Ernezel Director	rect	10e. Street and Number 10f. Zip Code		10g. Citizen of What	
56 Street death with the urterna 23a or 28a	<u>a</u> [	1901 E. Lombard Street Apt. 1 21231		United Sta	ates
ter de:	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 M No	y Yes or No- can, etc.)	- 14. Race - Ar Black, Wi	nerican Indian, nite, etc.
Maryland 21215-0036 d 2 should be filed within 72 hours aft the and Mental Hygiene. "ratural", or traumatic event, the Mulcel Exert traumatic event, the Mulcel Exert To Be Completed by E	by	1  Yes, Give Year or Dates: 1  Yes 2 M No Specify:		Specify: W	nite
72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Busines	ss/Industry
within within them	duo	Elementary/Secondary (0-12) College (1-4or 5+) Custodian		Municipal	Government
Ind Shied tal Hyg	ر ا ا	17. Father's Name (First, Middle, Last)  18. Mother's Name (F	irst, Middle,		
Ylai  Vial  Wanta barked  To F	0	Samuel Pudlin Sr. Catherine			
Mar id 2 sh tith and 27 Is m traum		19a. Informant's Name/Relationship (Type, Print)  Madeline Dreves — Daughter  19b. Mailing Address (Street and Number or Rural Rule)  1901 E. Lombard Street Ag			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene, important; if item 27 is marked other than "natural", or Hema 23e or 28e-1 show any injury or other traumatic avent, the Marical Ext., interfer us the intilities and once.	1	20a. Method of Disposition 20b. Place of Disposition (Name of Date		20c. Location - City	
Baltimore, Permit. Pages 1 s Department of He mportant: If item my injury or othe ons.		'4 Donation 5 Dother (Specify) Garrison Forest 09/14/2			lls, Maryland
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B760, water be executed hysician and the burial-transit the burial-transit executed the burial-transit executed the burial-transit executed the burial-transit executed the burial-transit executed the burial	LYa	23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respectively. In the disease of conditions are sulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Spiratory ar	rest,	Approximate Interval Between Onset and Death
Records, P.O. Box 68760, The law requires that the death certificate be e. tte has been signed by the attending physician page 2 should be detached for use as the buria	ysicialume	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No  9  Unknown  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  5 Other (specify)		23d. Date of d Month	elivery Day Year
rds, P. quires that n signed b	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute	to the cause of death?
Division of Vital Records, I or Attending Physician: The law requires t after death. Director: After this certificate has been signe I in by the funeral director, page 2 should be	nipier		24a. Was a autop	med? prior to death?	
/ital	u l	25. Was case referred to medical examiner?			s 2 No
Of V Physic this ca al dire	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home			ecity) haspry
ion of ading Physics: After this of funeral di		27. Manne of Death    28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   2 Accident investigation   28d. Month, Day Year   28d. Injury at Work?   1 Yes 2 No	I. Describe h	ow injury occurred	
Division ( Ital or Attending F at Director: After led in by the funers Certification:		3 Suigide 6 Could not be	Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	due to the cat the time, d	cause(s) and manner a date and place, and du	is stated. e to the cause(s)
To th withir To th comp		29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Mor	
		D40854		9/10/20	904
5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dund Riseberg 30? St Part 11 Baltimen	, a	1203	
State		31. Date filed (Month, Day, Year)  32. Registar's Signature			

		1. Deced	ent's Name	(First, Midd	le, Last)	)								2. Date of De				3. Time of Dea
Physic				,	V	ale	rie Y	/esko						Month Septem	Day	10.	Year 2004	
/Medi Exami		4a. Facilit	ty Name (If	not institutio	л, give s	street a	nd numbe	r)		4b. City,	Town, or	Location of	of Death	оер са			of Death	10.10
				e Town	Roa	ad #	<del>‡</del> 5					urnie	9		Ar	nne	Arun	del
Funeral Director		217	Security Nu.	2803	6. Sex	M 2	<b>X</b> <sub>F</sub> 7. A	nge (In yrs. 58	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Feb. 7	th ay, Year) 19	46	9. Birthp <i>Cour</i> <b>Ma</b>	place (State or Fo ntry) ryland
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or 28 be no	Director		et and Num		D					10f. Zip							Vhat Cour	ntry?
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Department of Heali Important: If Itam 2 any Injury or other once.		21. Sign	John Fur	neral Service	Liense	00 Co-50		· ·	/ 22	2. Name an	d Addres	s of Facilit	y Go	nce Fur	neral	. Se	rvice	P.A. yland 21
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			For State	State of Maryla				Mental Hygi	ene	5 <sup>70</sup> A 3 <sup>10</sup> A 11 <sup>2</sup> A 4
			Registrar		<i>Ce.</i>	rtificate of	Death	<del>,</del>	g. Nó.	28919
	hysici: /Medic		1. Decedent's Name (First, Middle, Last) TheLmA	A.	youn	9		2. Date of Death Month Septemb	er 7, 200	04 11:10 PM
E	xamin	er	4a. Facility Name (If not institution, give s HABORSIDE HE	alth Cente	R		or Location of Death		4c. County of D	eath
	neral ector		214-20-0239	7. Age (In y	rs. last birthday) 79 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9. 6 -1925 M	Birthplace (State or Foreign Country) NARYLAND
Aaryland	To Day	ō	Usual Residence of Decedent  10a. State 10b. County  Md.,	10c.	City, Town or Lo	more				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
with the !	be notifi	Director	10e. Street and Number 17/4 E 31	st Stree		10f. Zip Code	10	10	g. Citizen of What	
eath	I I I I	era		12. Was Decedent Eyer in		212		acify Vas or No-		7 merican Indian,
17215-0036 within 72 hours after death with the Maryland ene.	matic event, the Madical Examiner must be notified at	by Funeral	1 Never Married 2 Married 3 1 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cub	Hispanic Origin? (Sp fan, Mexican, Puerto Specify:	Rican, etc.)	Black, W	
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d within jiene.	IVe Ma	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		nitoria	during most of worked)		Court +	
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene.	ic event.	To Be C	17. Father's Name (First, Middle, Last)	rett			18. Mother's Nam	e (First, Middle, M 2 Wate		
Mar Ith ar	r trau		19a. Informant's Name Relationship (Type William F Young	(- )	19b. Mailir		and Number or Rur		City or Town, State	2/206
	y or othe		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □R  4 □ Donation 5 □ Other (Specify)	emoval from State	Place of Dispo cemetery, crei	sition (Name of matory or other pla nd Vetel	ice)	Date 2	Oc. Location - City	
Balti permit Deparm	any injury or one		21. Sign sture of Fune of Service License			2. Name and Addre		39 N. BE	cadary	Balto. Md.
	- W G		23a. Part1. Enter the disease, or complic	cations that caused the de	eath. Do not ent	er the mode of dying	ng, such as cardiac	or respiratory arres	F. C.	Approximate
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VITAI sician: ]	irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No	ospital: 1   Inpatient 2	☐ ER/Outpatien	. aclino. Ott		h (Check only one,		
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UIVISION OF VICEL  To the Hospital or Attending Physician: The within 24 hours attended to the Truth of Invarian Director, street his confinence.	d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
e Hospita 24 hours	etely fille	Medical C	29a. Certifier (Check only one)	ician: To the best of my ker: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the tirvestigation, in my c	me, date and place, opinion, death occurr	and due to the cau red at the time, dat	se(s) and manner e and place, and d	as stated. ue to the cause(s)
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V	\		29b. Signature and title of certifier  30. Name and address of person who cor  30. Let Kal	npleted cause of death (I	tem 23a) (Type	Brint) les	iele,	rd-	21239	7 ,
R	Sta egistr	te	31. Date filed (Month, Day, Year) SEP 1 3 2004	32. Registrar's Sig	nature					

		State of N  State of N  Registrar AMEND TTEM #7 PER		artment of Heal rtificate of Dea		al Hygien Reg. N	2001	28920
2000		1. Decedent's Name (First, Middle, Last)	rii 6030 107	01/04 011	2. 0	ate of Death	ay Year	3. Time of Death
Physic /Medi		Peter Michael Zawadzki		,		eptembe:		
Exami		4a. Facility Name (If not institution, give street and number	or)	4b. City, Town, or Loca			c. County of Dea	ith
		630 E. 31st. Street	Age (In yrs. last birthday,		ltimore Under 24 Hrs. 8 Da		N/A	tholace (State or English
Funeral Director		045-32-0137 125M 2□F	63 64 Yrs.		ours Min. (A	ate of Birth Nonth, Day, Yea 11 16,	r) 3.60 1941 C	rthplace (State or Foreign ountry) I'
and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
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death with the Maryland ms 23s or 28s-f show rmset be rediffed at	Director	10e. Street and Number	Dareimo	10f. Zip Code		10g. C	citizen of What C	ountry?
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death	Funeral	11. Marital Status 12. Was Decede Armed Force	nt Ever in U.S. 13.	Was Decedent of Hispan If Yes, specify Cuban, Me	nic Origin? (Specify Y	(es or No-	14. Race - Am Black, Whi	
or Ite	Fu	1 Never Married 2 Married 1 Yes 2	]No	./	pecify:	, 0.0.7	Specify:	10, 010.
15-0036 72 hours after dea "natural", or flems	d by	3 ☐ Widowed 4 ☑ Divorced Year or Date	s: 64-65			1	Wh	ite
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re, Maryla should theath and Men Heath and Men tem 27 Is marke other treumatic	L <sub>O</sub>	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street and N			or Town, State,	Zip Code)
Ma Inth ar 27 16		Peter A. Zawadzki/Son	5016	5 N. 6th. St	reet, Arl	ington.	VA 2220	)3
re, s 1 au f Head		20a. Method of Disposition	20b. Place of Disp		Date	20c.	Location - City o	
Pege ento		1 ☐ Burial 2 Scremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ite	ake Cremato		10 14 Be	ltsvill	e, MD
Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural; or eny injury or other traumatic event, the Medical Examples.		21. Signature of Funeral Service Licens e		2. Name and Address of	Facility			
m ggggg		- BATATE I HAVY ALS	2/	Cremation a 8717 Green				re. MD
	1	23a Part . Enter the disease, or complications that caushock, or heart lailure. List only one cause on each	sed the death. Do not en	nter the mode of dying, su-	ich as cardiac or resp	oratory arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	rescloset	ic Cardio	ansal.	r 1)'s	Pase	Onset and Death
/Medical		resulting in death)	as a consequence of):		in a section	9 60		
Examiner		Sequentially list conditions b.						
D #	iner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	se a consequence of):					
ecute and trans	Examiner	Cause (Disease or injury that initiated events c	as a consequence of):					
760, te be executed ysicien and ne burial-transit	cal E	Sub-to-(or	as a consequence or,					
cate physic the t		d						
of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed rhis certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23c. If yes, outco	me of pregnancy				23d. Date of de	alivery
Bo eath o	cian	in the past 12 months?	n 2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			Month	Day Year
ched the d	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown						
that the deta	Y P	Part II. Other significant conditions contributing to deal	h but not resulting in the	underlying cause given in	Part I.	23e. Did tobacco	use contribute	to the cause of death?
rds ruires n sign	P					1 🗌 Yes	2 □ No 3 □ F	Probably 4 Unknown
W rec	Completed					24a. Was an		autopsy findings available
Re la he la age 2	Ë					autopsy performed?	death?	
n: T	Be C	25. Was case referred to medical		26.	. Place of Death (Chi		10 12.0	
ysicia ysicia is cer direct	To B	examiner? 1 Yes 2 N	atient 2 ER/Outpatie	ent 3 DOA Other: 4	UNursing Home	Residence	6 ☐Other (Sp	ecify)
g Ph g Ph er th	12	27. Manner of Death 1 Natural 5 Pending 28a. Date of (Month,	Injury 28b. Time Day Year) Injury	of 28c. Injury at Work?	28d. l	escribe how in	jury occurred	
Division of Vital Records, P.O. Box 68 or attending Physician: The law requires that the death certifical after death.  Director: After this certificate has been signed by the attending phy in by the funeral director, page 2 should be detached for use as the	Certification;	2 Accident investigation		M 1 Tes	2 🗆 No			
Vision Attender de recto	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place of building	Injury - At home, farm, s , etc. (Specify)	treet, factory, office		ocation (Street City or Town, Sta		Rural Route Number,
Div					Salara Tables			
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier 1 Certifying Physician: To the bas one) 2 Medical Examiner: On the bas and manne	is of examination and/or i					
To the within 2 To the complet	Med	one) and manne  29b. Signature and title of certifier 1	Janes.	29c. License nui	mber	29d. [	Date signed (Mor	nth, Day, Year)
F 3 F 8		100 111 1K		0			( )	
120		30. Name and address of person o completed cause	of death (Item 23a) (Tues	Print)	6/	to	Junge	1 7, 2007 1 71291
7		oc. Name and address of person to completed cause	O. Journ (nom 20a) (Type	con B	/W. C.)	- 200	Ba Ho	TH 71744
S	tate	31. Date liled (Month, Day, Year) 3 2004 32. P	sistrar's Signature	1	Jana !	1	,	
Regis		SEP 1 3 2004	were so	Sport of the same				

		ı	1 - For State Registrar	State of Marylan		artment of		nd Mental F	lygiene Reg. No	1001	28921
	Physici	an	Decedent's Name (First, Middle, Last)  T TIME TO THE PROOF TO THE					2. Date of Month	Death Da	y Year	3. Time of Death
}	/Medic Examin		LENA V. BENHOFF  4a. Facility Name (If not institution, give si	treet and number)		4b. City. Town.	or Location of I	AUGUS		2004 County of Deat	5:20AM M
	LXami	۱	CORSICA HILLS NUT				REVILLE			UEEN AN	
	Funeral Director		213-10-4132	7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Yea Months Days			Birth Day, Year) 0 192	9. Birt Co MA	hplece (State or Foreign nuntry) RYLAND
	land DW		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	Mary I-1 sh	tor	MD CAROLIN	E E	EDERAL	SBURG					Yes 2 □ No
	or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Cit	tizen of What Co	ountry?
	ath w	rai	509 OLD DENTON RD			2163				USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-1 show other traumatic event, the Mudical Exameratinat be coefficial	by Funerai	11. Marital Status  1 Never Married  Married  3 Widowed 4 Divorced	<ol> <li>Was Decedent Ever in U Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:</li> </ol>		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 <b>X</b> N	ban, Mexican, F	i? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit Specify: W	
Maryland 21215-0036	"nature	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occi kind of work don DO NOT use retii	e during most o	f working	16b. K	and of Business	Industry
72	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M.	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		NDER	<del>6</del> 0)		7AW	ERLY PR	ESS
פַ	be filed stat Hygie of other event, the	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Mid			
<u>  Yaa</u>	should b and Menti s marked umatic e	To	CHARLES D. WATTS				INA	NABELLE (	COOPER	3	
Mar	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship (Type GEORGE F. BENHOFF/)		5	-		or Rural Route Nu FEDERALS			
	s 1 an I Heal Item 2 other		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of	1	Date		ocation - City or	
E	Pages nent of I nnt: If its nry or o		1 XBurial 2 ☐ Cremation 3 ☐ Re  `4 ☐ Donation 5 ☐ Other (Specify)	moval from State	-	natory`or other pi MEMORTAI	' I	8-27-2004	4 EAS	STON, MA	RYLAND
Baltimore,	permit. Pages 1 and 2 Depertment of Health a Importent; If item 27 is any injury or other tra once.		21. Signature of Funeral Service License		FE	2. Name and Add	ress of Facility HELFENBI	EIN & NE	I MANV	FUNERAL	
.£.			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the deat	h. Do not ent	er the mode of d	ring, such as ca	ST EASTO	y arrest,	21601	Approximate Intervat Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			12eu	untic				Onset and Death
	Examiner			Due to (or as a conseq	juence of):						
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	uence of):						
	and and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	juence of):						
8760,	cate be executed obysician and the burial-transit	dical	d								
9	eath certifica attending ph for use as tl	/Med	IF FEMALE:	Bc. If yes, outcome of pregna	2000						
.O. Box	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Use birth 2 Feta 4 Pregnant at time of c	Il death 3	Ectopic pregnan Other (specify)	су		- 1	23d. Date of del Month	Day Year
Δ.	quires that n signed b uld be deta	by	Part II. Other significant conditions conf	t <i>r</i> ibuting to death but not res	ulting in the u	nderlying cause o	pven in Part I.				the cause of death?
Vital Records,	he law requir has been si ge 2 should	Completed						a	vas an utopsy erformed?	24b. Were au prior to death?	utopsy findings available completion of cause of
ta		a	25. Was case referred to medical				26 Place of	1 ☐ Ye  Death Check or	s 2 No	1 Tes	2 □ No
	Physicien: this certificatal director, I	ToB	examiner?	ospital: 1   Inpatient 2	ER/Outpatier	nt 3 DOA	ther	ing Home 5 - F		6 ☐Other (Spe	cify)
Division of	anding Ph lath. pr: After th		27. Manner of Death  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W	ury at ork? □ Yes 2 □ No		be how inju	ry occurred	
Divis	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	reet, factory, offic	e	28f. Locatio City or	n (Street ai Town, State	nd Number or Ri e)	ural Route Number,
	e Hosp 24 hou e Fune letely fill	edical	29a. Certifier (Check only one)  Check only one)	ician: To the best of my known; or: On the basis of examination and manner stated.	owledge, death ation and/or in	h occurred at the vestigation, in my	time, date and i	place, and due to occurred at the tir	the cause(s ne, date an	and manner as d place, and due	s stated. to the cause(s)
	To th To th compl	Me	29b. Signature and title of certifier	^		29c. Lice	nse number			ate signed (Mont	
			1 Jan V apr	(muse			0720	36	8	125/2	684
			30. Name and address of person who cor	in D	n 23a) (Type,	Print)	rive (	les ky.	~ 0	2161	ç
¥	Sta		31. Date filed (Month DIGY 2) 6 20	32 legistrar's Signa	ature	La plu				(	
	Registr	ar		13 years	A. William						

			1 - For 8-30-04	State of Mary	rland / Dep	artment of H	lealth and	Mental Hyg	iene		
			Registrar Amend #18	Per FH RGC or	Ce	rtificate of	Death		g. No.	11.	22022
*	Physici		1. Decedent's Name (First, Middle, Mildred Eli	•	a11			2. Date of Deat Month Aug.	_	Year 04	10:00A M
	/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Deat		4c. County		10.00A
		70,	15605 Evergla	ide Ln. Ap	t. 102	Box	wie		Princ	e Ge	orge's
	Funeral		,	3. Sex 7. Age (In 1  M 2 X F	yrs. last birthday	If Under 1 Year   Months   Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl Count	ace (State or Foreign
150	Director		579-07-7477 Usual Residence of Decedent	10 W 2001	91 Yrs.			Jun. 10	,1913	Mary	land
	yland low		10a. State 10b. County	10	c. City, Town or L	ocation				10	Od. Inside City Limits
	a-fsh	ctor	MD Prince	e George's	Во	wie					1 Xes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of V	Vhat Count	try?
	s 23s	rall	15605 Evergla		t. 102		716		USA		
	ter de Itams Irer n	Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie	12. Was Decedent Ever Armed Forces? d 1 Yes 2 No	r in U.S.   13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		e - America k, White, e	
980	ursaf al', or Evam	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	ļ	1☐ Yes 2☐XNo	Specify:		Specify	Whi	te
2-0	be filed within 72 hours after death with the Maryland ntal Hygiene. od other then "natural", or Itams 23s or 28e-1 show evant, I're Madical Evarriner must be rodified at evant, I're Madical Evarriner must be rodified at	Completed	15. Decedent's	Education		edent's Usual Occup		rking	16b. Kind of Bu		
21	within ene. than "	mple.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)	, and			
2	filed withi Hygiene. othar than ant, Ine M		1 2 17. Father's Name (First, Middle, La	ast)		Homemake		ne (First Middle A		hom	е
lan	should be nd Mental marked o	To Be	Joseph Ryar				Ella	me (First, Middle, M Thirles	alden somani	10)	
ary		-	19a. Informant's Name/Relationship		19b. Mail	ing Address (Street				State, Zip	Code)
Σ	is 1 and 2 of Health a itam 27 is othar trae		Mary E.McCrill	is/daughte:	r 1708	Pittsfi	ield La	ne Bow	ie, MD	. 20	716
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3		Ob. Place of Disp cemetery, cre	osition (Name of matory or other place	e)	Date 2	20c. Location -	City or Tov	vn, State
tim	permit. Pages Department of I Important: If its any injury or of		*4 □Donation 5 □ Other (Spe	ocify)	Holy Tr	inity Ce	em. 8-31	-2004 I	Bowie,	MD.	
Bal	Depari Depar Impor any ir		21, Signature of Funeral Service Li	censie		2. Name and Addres					
r	3.		23a. Part1. Enter the disease, or co	omplications that caused the		512 NW (					U / I 5 Approximate
b	Pnysician		shock, or heart failure. List or Immediate Cause (Final	nly one cause on each line	1.		3,	or respiratory unio	.,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a co	insequence of):						
B	Examiner		Sequentially list conditions	b							
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):						
	xecute and Il-tran	Examine	that initiated events resulting in death) Last	c Due to (or as a co	nsequence of):						
8760,	be icia bur	dicai E			,						
9	tificate ig phys as the	ledic									
Вох	death certificate attending place as to death of the control of th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		□Ectopic pregnancy				e of deliver	
0	0 0 0	hysician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown		Other (specify)	_		Mor	itn L	Day Year
Ф.	that the dined by the detached	Δ.	Part II. Other significant condition	s contributing to death but no	ot resulting in the u	underlying cause give	en in Part I.	23e. Did tob	acco use contr	ibute to the	cause of death?
rds	es igr	ed by						1 🗌 Ye	s 2 10 No	3 ☐ Proba	bly 4 ⊡Unknown
Vital Record	> 00	Completed						24a. Was an		Vere autop	sy findings available
Ä	The ate h page	Mo						autopsy perform 1 Yes 2	ed?	eath?	pletion of cause of □ No
/ita	Physician: The this certificate ral director, page	Be (	25. Was case referred to medical examiner?					ath (Check only one			
of	y s	2	1 ☐ Yes 2 ☑ No 27. Manner of Death		2 ER/Outpatie		4   Nursing H	ome 5 Resider			
	After After fune	tion	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	Worl	/ at ⟨? Yes 2 □ No	28d. Describe how	w injury occurre	∍d	
Division	deal deal ctor: y the	ertification:	3 Suicide 6 Could no	t be 28e. Place of Injury -	At home, farm, st			28f. Location (Str.	et and Numbe	er or Rural	Route Number,
Ö	in Dire	Certi	4  Homicide	building, etc. (S	pecify)			City or Town,	State)		
	To tha Hospital within 24 hours a To tha Funaral I completely filled	edical (	(Check only 2 Medical E)	Physician: To the best of my caminer: On the basis of exa	y knowledge, deal mination and/or in	th occurred at the tim	ne, date and place pinion, death occu	, and due to the car rred at the time, da	use(s) and mar te and place, a	nner as sta	ted. he cause(s)
	To tha within 2 To tha comple	Med	one)  29b. Signature and title of certifier	and manner stated.			number		d. Date signed		
	FSFő		Moder	Lesh !		030	1109	8	28/	4	
C	R (2)		30. Name and address of person wh	no completed cause of death	(Item 23a) (Type,	Print) Ceru	1 est	D 2	1061	Mic	hael Sulvis
	Sta		31. Date filed (Month, Day, Year)	39 Registrar's S	Signature		7			, , , ,	MI
	Registr	ar	AUG 3 0 20	U4 Beauce	# Apo	New York					

			1 - For State Registrar	State of Maryland	-		lealth and			004	28923
			1. Decedent's Name (First, Middle, Last	)				2. Date of Dea	th		3. Time of Death
	Physici /Medi		Pansy Me	elvinia Bowins				August	31	200 <b>4</b>	7:20 a M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	h	4c. C	County of Death	
r			Frederick Memo	rial Hospita	1	Frederi	ick		F	rederi	ck
	Funeral Director		5. Social Security Number 6. Se 218-30-8653	x 7. Age (In yrs. la.	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	9. Birth	place (State or Foreign intry)
	72 hours after death with the Maryland neture!; or Items 23a or 28e-f show dical Examinational be captified at	ector	10a. State 10b. County Md. Frederi		Town or Lo	town					10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	23a or	Funeral Director	5152 Doub	s Road		10f. Zip Code	1710	1	-	en of What Cou	ntry?
920	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "neturel", or Items 23a or 28e-f show other then "neturel", or Items 23a or 28e-f show event, the Medical Evandrating the rollified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1Yes _ 2No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		4. Race - Americ Black, White, Specify: Black	etc.
21215-0036	within 72 ho ene. then "netur he Medicel	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation (e completed) College (1-4or 5+)	(Give life. L	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wo )	rking	16b. Kind	d of Business/In	dustry
Maryland 2	buld be filed Mental Hygid arked other etic event, L	To Be Co	17. Father's Name (First, Middle, Last) Alfred Weed	lon			Mary				
	s 1 and 2 should if Health and Mer item 27 Is marke other treumetic		19a. Informant's Name/Relationship (Tyles 1900)  Linez Boozev  20a. Method of Disposition	(dau)	25 W	Indham	Dr. Hun	tington	Stat	ion, New	syork"
Baltimore,	Page tent o nt: If		1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signatuse of Funeral Service Lisens	Fair	View	sition (Name of natory or other place	Sept.	4,2004	Free	d. Md	own, State
Ba	permit, Departm Importe eny inju		> pany &. fol	leis		Name and Address				ne 1d Zi1	01
	Pnysician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. a. <u>Acule</u> on	, Ch				est,		Approximate Interval Between Onset and Death
	Examiner	ler	Sequentially list conditions, if any, leading to immediate eases. Enter Underlying	Due to (or as a conseque		12.000		-			10mg
8760,	icate be executed physician and s the burial-transit	Ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a conseque	nce of):						
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnanc 1  Live birth 2  Fetal d 4  Pregnant at time of dea 9  Unknown	eath 3□	Ectopic pregnancy Other (specify)			23	d. Date of delive	ery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions con	ntributing to death but not result	ing in the ur	nderlying cause give	n in Part I.		acco use		ne cause of death?
	The ate ha	Completed	-CHF					24a. Was ar autops perform 1 Yes 2	y ned?	prior to cor death?	psy findings available inpletion of cause of 2 No
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	fospital:		04		th (Check only one			
n of	ng Phys fter this	tlon: To	1 Yes 2 No   27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Inpatient 2 E	NOutpatient 8b. Time of Injury	28c. Injury Work	- Indising in	ome 5 Reside 28d. Describe ho			/)
DIVISION		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre			28f. Location (Str. City or Town	reet and f , State)	Number or Rura	I Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical (	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of my knowledger: On the basis of examination and manner stated.	edge, death n and/or inv	estigation, in my op	inion, death occu	rred at the time, da	ite and pl	ace, and due to	the cause(s)
	To the within To the comp	Me	29b. Signature and fitle of certifier	J.		29c. License	number 43091	Ave ,	9 d. Date s	signed (Month, I	Day, Year)
			30. Name and address of person who co		3a) (Type, F	Print) TOLL	House	Ave	Fre	elenli	MD
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 1	32. Registrar's Signatur	re /	5 Spe	uls	6			

			For State	State of Marylan	•	artment of tificate of			1	2001	200	101
		4.7	Registrar  1. Decedent's Name (First, Middle, La	et)	Cei	uncate of	Dealii	2. Date of Dea	Reg. No.	UUU	3. Time o	of Death
5	Physici /Medic		BETTY A.	DeShiel	ds	Burge		Month 68	Day 24	04	11:50	_
	Examin	er	4a. Fecility Name (Pnot institution, give 3050) Pecan T	e street and number)		Da	or Location of Dea	ith	4C.	County of Dear	1.	
				Sex 7. Age (In yrs.	last hirthday)	If Under 1 Yea	r If Under 24 Hr	s. 8. Date of Birt	h	On Bird	boloon (State	or Foreign
	Funeral Director			1 □ M 2 2 1 1	6 Orrs.	Months Day			v. Year)	1 C	ountry) D	L.
	-		Usual Residence of Decedent					01-01	4 - L			<u>r.</u>
	yland		10a. State 10b County	10c_Cit	y, Town or Lo	cation					10d. Inside C	City Limits
	Mar	ţō	MD Some	RSET	TINCE	ss A	nne.				1 (2K)(es	s 2 □ No
	r 28g	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Co	untry?	
	hours after death with the Maryland turel', or Items 23e or 28e-f ahow al Examiner must be notified at		30739 Antioch	AVE			1853			U.S.	A	
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13. V	Was Decedent of	Hispanic Drigin? (	Specify Yes or No- rto Rican, etc.)	.	14. Race - Ame Black, Whit		
9	or Ite	F	1 ☐ Never Married 2 🔀 Married	1 ☐ Yes 2 Mo If Yes, Give		1 ☐ Yes 2 <b>2</b> € N		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Specify!	21 1	
8	irel',	d by	3 Widowed 4 Divorced	Year or Dates:							slach	
5-	72	Completed	15. Decedent's E (Specify only highest gr	ducation ade co <i>mpleted)</i>	(Give	lent's Usual Dcci kind of work don	e during most of w	orking		nd of Business	0 1	
12	within iene. than "	m	Elementary/Secondary (0-12)	College (1-4or 5+)	- III 6. L	OO NOT use retir			<u>ي</u>	merson	Count	L
2			17. Father's Name (First, Middle, Las.	, 4 yrs		1 EAch		ame (First, Middle,	Maiden		Educa	149V
and	ed all all all all all all all all all al	Be	C1 1 1-9	20			1	-				
Ë	should nd Men marke umartic	P	19a. Informant's Name/Relationship	Shields	10h Mailin	n Address (Street	· · · · · · · · · · · · · · · · · · ·	T₁€ a Rural Route Numbe		Town State	Zin Code)	
Maryland 21215-0036	12 ha 7 is		2	A	70730	. A . I	1 Aur	D	A A	111		62
_	1 an Heal em 2 ther		ENOCH Burgess 20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of		Princess Date	20c. Lo	cation - City or	Town, State	55
و	0 -	1	1 Burial 2 ☐ Cremation 3	Removal from State	emetery, cren	natory or other p		00.1				11
Baltimore			<ul> <li>4 □Donation 5 □ Other (Special</li> <li>21. Signature of Funeral Service Lice</li> </ul>		Mark	3 Cemes		28-04	Tri	ncess -	enne, A	M
Bal	permit. Departr Importe eny inje		21. Signature of Fulleral Service Lice	8 6 6	A	Name and Add	E. Ward	funeral	Hou			a
			23a. Part1. Enter the disease, or con	polications that caused the deat	b Do not ente		noden Ave	- Vrince		mne, 1	Approxima	<u>853</u>
21			shock, or heart failure. List only	one cause on each line.	The Bornot entit	ه ۱۱۱۵ ۱۱۱۵۵ ۱۱۵	// /	ac or respiratory ar	1631,		Interval Be Onset and	tween
8	Physician		tmmediate Cause (Final disease or condition resulting in death)	a. Melasla	lie (	envil	ial la	ncinon	ra		6 Mon	the
10-4	/Medical Examiner		1	Due to (or as a consec	uence of):							
		_	Sequentially list conditions,	b. Due to (or as a conseq	uence of):							
	ted 1sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0. 00 0 00.000	20.100 01).							
	xecu and	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):							
8760	ate be executed hysician and the burial-transit			0.3								
687	ficate phys s the	edicai	W.	_ d								
	the death certific y the attending pl iched for use as t	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					2	3d. Date of del	iverv	
Вох	eath atter	ciar	in the past 12 months?	1☐Live birth 2☐Feta 4☐Pregnant at time of c		Ectopic pregnan Other (specify)	су		-	Month		Year
o.	at the de by the	Physician/M	1 ☐ Yes 2 ☐No 9 ☐ Unknown	9□ Unknown								
٣	de de		Part II. Other significent conditions	contributing to death but not res	ulting in the ur	nderlying cause g	oven in Part I.	23e. Did to	bacco u	se contribute to	the cause of	death?
Sp.	n sign	d by						101	es 20	No 3□Pr	obably 4 🗆	]Unknown
00	w requir been s	Completed						24a. Was	an	24b. Were au	topsy findings	available
Re	The fav	E C						autop perfo	rmed?	prior to death?	completion of	cause of
B		ပိ	25. Was case referred to medical				26 Place of Dr	1 ☐ Yes eath (Check only o	2 No	1 ☐ Yes	2 No	
of Vital Records,	Physician: this certific ral director,	o B	examiner? 1 ☐ Yes 21 No	Hospital:	ER/Dutpatien	t 3 DDA C	then	Home 5 Resid		Dother /Son	day Dorrah	Lort His
			27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Inj	ury at	28d. Describe h			ony) Delagn	143 तामक
lo	ding I th. : After s funer	ţi	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		ork? ⊒Yes 2⊡No					
Division	Attending or death. ector: After by the fune	ifica	3 Suicide 6 Could not l	200. Place of injury - At n	ome, farm, str	eet, factory, office	<del></del>	28f. Location (5		d Number or Ru	iral Route Nur	nber,
ā	ē # 5 €	Certification:	4 - Hollicide	building, etc. (Special	у/			City or Tou	m, State)			
	To the Hospital within 24 hours and To the Funeral completely filled		29a. Certifier 1 Certifying P	hysician: To the best of my kno	wledge, death	occurred at the	time, date and place	e, and due to the	cause(s)	and manner as	stated.	
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medicet Exe	miner: Dn the basis of examina and manner stated.	ition and/or inv	restigation, in my	opinion, death occ	curred at the time,	date and	place, and due	to the cause(	s)
	To the I within 2. To the I	Ž	29b. Signature and title of certifier	A /		29c. Licer	se number		29d. Date	signed (Monti	h, Day, Year)	
			1 Gal #1/	Tom w		DA	05677	6	5/2	3/04		
			30. Name and address of person who	completed cause of death (tter	m 23a) (Type,	Print)			1	1		
_			ROBERT L.	CLINTON, N	10.14	15 E.	PRROLL	ST. SH	LIS	BURY	MD =	21801
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	_						
	Registi	ar	AUG 2	7 2004	L	1. "						

Aug 30, David Clark Carpenter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 21 5. Social Security Number 6. Sex **Funeral** Days Hours Months Min. Director 217 60 6260 49 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 28a-f show ortant: If item 27 is marked other then "natural", or Items 23s or 28s-f sho injury or other treumatic event, its Medical Examiner must be natified at Leonardtown St. Marys Director Calvert Lusby Maryland 10e. Street and Number 20316 Chingville Road 10f. Zip Code 20650 10g. Citizen of What Country? 20657 250 Laurel Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 3 Widowed 4 Novorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any injury or other treumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard Allan Carpenter Frances Marguerite Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frances C. Stump (Sister) 250 Laurel Drive, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XXurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Resurrection Cemetery Sept 3 2004 Clinton, Maryland 21. Signature of Funeral Service Licenspe 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Rd, Clinton, Maryland 20735 1200257 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical **Examiner** 

1. Decedent's Name (First, Middle, Last)

**Physician** 

Amend item#10a-c, 10e-i, perint in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004

Year

Prince George's

1955 Maryland

United States

Specify:

Sheet Metal

14. Race - American Indian,

Black, White, etc

4c. County of Death

3. Time of Death

Birthplace (State or Foreign Country)

White

Approximate

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

3:15 A M

2. Date of Death

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit attending physician for use as the buria Division of Vital Records, P.O. Box 68760,

ed by the a detached f

filled in by the

within 24 hours a To the Funerel L

Immediate Cause (Final disease or condition resulting in death)	a. Cirrho	sis of	2 7	iver				Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consec	quence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of a 9 □ Unknown	al death 3 □Ect	opic pregn her <i>(specif</i>			2	3d. Date of delin	very Day Year
Part II. Other significant conditions co	ontributing to death but not re-	sulting in the under	rlying caus	e given in Part I.		obacco us		the cause of death?
					24a. Was auto perfo 1 🗆 Yes		24b. Were aut prior to co death? 1 \( \subseteq Yes	opsy findings available ompletion of cause of
25. Was case referred to medical examiner?	Hospital: 1×npatient 2	] ER/Outpatient :	3□ DOA	Othor	eath (Check only o		Other (Spec	(fy)
	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work?	28d. Describe			.,,,
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, street, fy)	factory, of	fice	28f. Location ( City or To	Street and wn, State)	l Number or Rui	al Route Number,
27. Manner of Death   X Natural   5   Pending     Could not be determined	vsician: To the best of my known iner: On the basis of examinating and manner stated.	owledge, death ocation and/or invest	curred at thi	ne time, date and plac my opinion, death occ	e, and due to the curred at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)
29b. Signature and tille of certifier	n	~mp		005321	9	29d. Date	signed (Month)	
30. Name and address of person who c	ompleted cause of death (Itel			fice Roa		Long	FIND	20602

State Registrar 31. Date filed (Month, Day, Year)

32. Registar's Signature

		1 - State Registrar Certificate of Death	Reg	. No.?	2992
Physicia	n	1. Decedent's Name (First, Middle, Last)	Month	Day Yeer	
/Medica	<b>31</b> -	Mary Shane Davis  4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	August 3	4c. County of De	5:30 P
Examine		Heartfields Assisted Living Frederick		Frederick	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, )		irthplace (Stete or Fore Country)
Director		524-12-3272 1 M 2X F 84 Yrs. Months Days Hours Min.	Nov. 23,	1919 Ne	ebraska
100		Usual Residence of Decedent         10c. City, Town or Location           10a, State         10b. County         10c. City, Town or Location			10d. Inside City Lim
sho In La	٥				1 X Yes 2 □ I
ms 23a or 28a-f show	Director	Maryland Frederick Frederick  10e. Street and Number 10f. Zip Code	100	. Citizen of What C	Country?
3a or	ā	916 Pontiac Avenue 21701	US	A	
ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Am Black, Wh	
or Its	F	1 🕅 Never Married 2 ☐ Married 1 📉 Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 🖾 No Specify:	7 (104), 5(5.)	Specify:	me, etc.
ene. than "natural", or Ite	d by	3 Widowed 4 Divorced Year or Dates:	11	W	hite
net	Completed	15. Decedent's Education (Specify only highest grade completed)  [Second of the completed]  [Second of the completed]  [If the DO NOT use retired]	king   16	Bb. Kind of Busines	s/Industry
than than	E	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Chemist		S Militar	y Installa
Hygi other ent.	BeC		ne (First, Middle, Ma		y Instaria
ked ked	To B	Annan Clay Davis Blanche	Eugene As	tin	
s mar		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rule)	ral Route Number, (	City or Town, State,	Zip Code)
alth alth a		Barbara Davis Hollinsworth, sis. 40 Lakeside Trail, Fa	irfield,	PA 17320	)
of He		20a. Method of Disposition  1 Burial 2 XCremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  9/1/2	Date 20 2004	c. Location - City o	r Town, State
ant: h		'4 □ Donation 5 □ Other (Specify) Western MD Cremation Servi	ce Fr	ederick,	
portion.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. Ite Medical Evan it at must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keep 106 East Church St.			
MARKET !		23a. Part1. Enler the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac shock, or the inf failure. List only one caus on each line.			Approximate Interval Between
hysician		Immediate Cause (Final disease or condition a End Stage Breast Cancer with Metas			Onset and Death Years
/Medical		resulting in death)  a. End Stage Breast Canter with Netas  Due to (or as a consequence of):	tasis		Tears
xaminer		Sequentially list conditions Hypertension			Years
: :: ·:	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Coronary, Artory, D.T. and Coronary, D.T. and Coronary, D.T. and Coronary, D.T. and Coronary, D.T. and			
attending physician and for use as the burial-transit	Examiner	cause to leade of injury that initiated events resulting in death) Last  Coronary Artery DIsease Due to (or as a consequence of):			Years
sician	caiE				
phys s the		d.		•	
r death.  Cleath.  Sctor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of de	elivery
ed by the attendir	lcia	in the past 12 months?  4 Pregnant at time of death 5 Other (specify)	7/	Month	Day Year
by the tached	hys	9 ☐ Unknown			
s been signed to	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
is ue	ted	Gastroesophageal Reflux Disease	1 Nes	2 No 3 □ F	Probably 4 Unkno
as be	pie		24a. Was an autopsy	prior to	autopsy findings availa o completion of cause i
page	So.		performe	d? death? SiNo 1 ☐ Ye	
is certificate ha	Be	examiner?	th (Check only one)		
this c	၀	1 ☐ Versing Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hospital: 28a. Date of Injury 28b. Time of 28c. Injury at	ome 5 Residen		ecify)Asst.'d
After funer	lon	1 X Natural 5 ☐ Pending (Month, Day Year) Injury Work?	20d. Describe now	injury occurred	
death ctor: y the	lica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stre	et and Number or F	Rural Route Number,
after Dire	Certification;	4 Homicide building, etc. (Specify)	City or Town,	State)	
Frozense of American Francis after death. Francis of Aler etely filled in by the funer	calc	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and places (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	, and due to the cau	se(s) and manner a	as stated.
4 1 0	Medical	one) and manner stated.			
the the		29b. Signature and pile of certifier 29c. License number	290	J. Date signed (Mor	
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	2	1001 1 Fa. VII 1911 1954749	Sa	ntember i	. 2004
within 2 To the complei	2	29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)	Se	ptember l	., 2004

		For State Registrar	State of Maryland		irtment of H tificate of I			ene	04	28927
- · · ·		1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day	Year	3. Time of Death
Physici /Medio		Evelyn Willey	Dean				Augus	1 25	4006	1:45 PM
Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death	1	4c. Count	y of Death	
		Dorchester Genera	al Hospital		Cambri				chest	er
Funeral		5. Social Security Number 6. Sex	M STE	- "	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl Count	ace (State or Foreig
Director		214-07-9318	84	Yrs.			May 10,	1920		ryland
and and		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loc	cation				10	d. Inside City Limits
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel; or items 23e or 28e-f show any njury or other treumatic event, it is Medical Evantical Intel Le Lottified at ODGs.	ō	MD Dorches				ridge				1 X Yes 2 □ No
28e-	Director	10e. Street and Number	3002		10f. Zip Code	riage	1/	g. Citizen of	What Count	n(2
with the state of	ā	400 Talbot Ave.			101. 21p C000	21613				ту:
ns 23	by Funerai		12. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of H		pecify Yes or No-		S.A.	ın Indîan.
	F	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 No	l II	Vas Decedent of H Yes, specify Cuba	in, Mexican, Puert	Rican, etc.)		ck, White, e	
0,1	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specia	y: whi	te
atur	Completed	15. Decedent's Edu	cation	16a. Deced	ent's Usual Occupa	ation		6b. Kind of E	usiness/Ind	ustry
	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		ent's Usual Occupa kind of work done o OO NOT use retired		king			
giene arth	ю	11			secretary			food b	roces	sor
vent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, M	laiden Sumai	ne)	
Aenta rked tice	ည	Howard Willey				Carrie	Robbins			
s ma		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street a	and Number or Ru	ral Route Number,	City or Town	State, Zip	Code)
alth 27 i er tre		Carrie Hall	niece			ad, Cambi	ridge, MD	2161	3	
of He		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R		ace of Dispos	sition (Name of natory or other plac	e)	Date 2	Oc. Location	City or Tov	vn, State
unt: if		'4 Donation 5 Other (Specify)	emoval from State Doro	hester	Memoria	l Park 8	3/27/04	Cambri	dae I	MD
y of		21. Signature of Funeral Service License			Name and Address		nomas Fun			
lmpon any		Brian K. Bin	T-		700 Locus		Cambridge		21613	
Medical xaminer fransit	cal Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a consequence to for as a consequence to for as a consequence to for as a consequence to for as a consequence to for as a consequence to for as a consequence to for as a consequence to for as a consequence to for as a consequence to for as a consequence to for as a consequence to for as a consequence to for as a consequence to for as a consequence to for as a consequence to for as a consequence to for as a consequence to for as a consequence to for a co	ence of):	A	urcinon				Interval Between Onset and Death 3 4 hours
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signe bed	þ	Chronic obstructi	,	^	, ,	mmeant.				bly 4 Unknown
peen s	etec	CHOKIE OBSITACIO	V parmones	7 0150	~ 36					
hast e 2 s	id						24a. Was an autopsy perform		Were autop prior to com death?	sy findings available pletion of cause of
cate,	Ö						1□ Yes 2		1 ☐ Yes 2	2 🗆 No
ector	Be	25. Was case referred to medical examiner?	lospital:		04-		th (Check only one	)		
within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	ဥ	I Tes 2 III NO	1 A Inpatient 2 L	R/Outpatient		4   Nursing H	ome 5 Resider			
After	Certification;	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how	v injury occur	red	
tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be	On Blood Miles			Yes 2 □ No	Oof Longtine (Ch.			0
irer o	ŧ	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, tarm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Numb State)	oer or Rurai	Route Number,
To the Euneral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Ce	(Check only 2 Madical Examir	sician: To the best of my knowner: On the basis of examinati	/ledge, death on and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the car	use(s) and mate and place,	anner as sta	ted. the cause(s)
the the	Med	one)	and manner stated.		29c. License	number	20	d. Date signe	d (Month D	av Voarl
× = 00	-	29b. Signature and title of certifier	100		250. Licerise		29	_		
		1000	Cth, h	1. D.	U'	20804		9	-25-1	74
		30. Name and address of person who co	impleted cause of death (Item		- 1	( 1 (	) ,,	01/		
		31. Date filed (Month, Day, Year)	M. D. TO& B.  32. Registrar's Signati	yrn 5	treet	combo, v	go, MU	216	5	
Sta		ur. Jaro mog (MUNI), DAV. I HAIT	I UE. I TOMOURAL S CIGITAL				4.1			

State of Maryland / Department of Health and Mental Hygiene - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 AUGUST 10:30AM NELLIE M. DUNN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. MICHAELS TALBOT 24922 BARRETT LANE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APR 14 1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Days Hours 84 Yrs. MARYLAND 220-05-8411 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits in then "naturel", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director TALBOT ST. MICHAELS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24922 BARRETT LANE 21663 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify WHITE <u>\$</u> 3X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry oe filed within 7. al Hygiene. I other then "n College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fi of Health and Mental F item 27 Is marked ot CLIFTON LEWIS MURRAY ELIZABETH DADDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS GANZZERMILLER/DAUGHTER 24922 BARRETT LANE, ST. MICHAELS, MD 21663 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State ^ 4 □ Donation 5 □ Other (Specify) OLIVET CEMETERY 8-28-2004 ST. MICHAELS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE Pnysician EARS /Medical Due to (or as a consequence of): **Examiner** REMAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a noneequence of) Examine the attending physician and hed for use as the burial-transit death certificate be executed RESPIRATORY DISTRESS Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed CHRONIC OBSTRUCTIVE PURMONARY DISPASE 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 21€ No ABDOMINAL ADRTIC ANEURYSM 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 27 No Certification; To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Hospitel or Attending Pt 24 hours after death. Funerel Director: After th 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/23/04 20057967 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 607 DUTCHMAN'S LANE EASTON MD 21601 DAMIAN SOOKLAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 25 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year HARRY /Medical DAVIS AUGUST 26, 2004 9:55A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10118 GRIFF DRIVE FORT WASHINGTON PRINCE GEORGES 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) XXM 2□F Days Months Hours Director 80 Yrs 577 26 2722 MAR. 10, 1924 CLINTON, Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Director XXYes 2 □ No MARYLAND PRINCE GEORGES FORT WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? MIT item 27 is marked other than "natural", or Itams 23c or other traumatic event, the Mcdical Examinar must be in 9813 JACQUELINE DRIVE Funerai death 20744 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1XXYes 2 No 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after XIX Never Married 2 Married 1947-Baltimore, Maryland 21215-0036 1 Tes XX No þ Specify: 3 Widowed 4 Divorced Specify: BLACK Year or Dates: 1948 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10TH TRUCK DRIVER PRIVATE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 is markad othing any injury or other traumatic avent <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES DAVIS / FRIEND 9813 JACQUELINE DRIVE FT. WASHINGTON, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2000 Bremoval from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY AUG. 30, 2004 ALEXANDRIA, VA of Funeral Service 21. Sign vur 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 ter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. 23a. Part1. Er shock o Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) PANCREATIC CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760 Physician/Medical as esn. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. ☐Yes 2 ☐ No the 9 Unknown 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe 1 Yes X No Completed 3 Probably 4 Unknown need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 1 Yes 2 No XXNo 1 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) You Home XXYes 2 □ No 9 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Medical Certification: 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After Hospital or Attending XXNatural 2 Accident Month, Day Year) 5 Pending after death.

Diractor: Aff investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours XX Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifia 29c. License number 29d. Date signed (Month, Day, Year) Vellino James-D35206 AUGUST 27, 2004 30. Name and address of person who completed cause of d=th (Item 23a) (Type, Print) WILLIAM T. TANNER, M.D. 11701 LIVINGSTON RD. FORT WASHINGTON, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State AUG 3 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.) 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Lenore J. Dew 2004 August 30 1720 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 200 F 87 Yrs. Director October 22 1916 213-10-5181 MD Usual Residence of Decedent with the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or items 23e or 28e-f show the Madical Exeminer must be notified at 1 ☐ Yes 2/2 No Funeral Director MD Carroll Westminster 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1416 Warehime Road 21158 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. be filed within 72 hours after 1 □ Yes 2 🟋No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White à Specify: 3 ₩idowed 4 Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Department of Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Social Services ith and Mental Hygie 27 Is marked other treumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Thomas Crowson, Sr Lenora Logan Pages 1 and 2 should I nent of Health and Men 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The If item 27 lg r Joyce Andersen/daughter 1416 Warehime Road Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State pernit. Page Department of Importent: If any njury or once. Meadow Branch Cemetery 9/4/2004 Westminster, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Pritts funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final Physician disease or condition resulting in death) endrovasen accu /Medical Due to (or as a consequence of): Examiner RERTENSION Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to for as a gonsacuence of The taw requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Othersignificant conditions contributing to death but st resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has certificate 1 ☐ Yes → No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2- No Certification: To npatient 2 ER/Outpatient 3 DOA s after dea.
rel Director: After ...
v the funeral dir this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title 29c. License number 0 NS 20 Name and address of person who completed cause death (Item 23a) (Type, Print) 700A BURISMANKA MA GAN 31. Date filed (Month, Day, Year) 32. Registar's Signature State SEP 0 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 000 1. Decedent's Name (First, Middle, Last) 2. Date of Death S. Time of Death Month Day Year **Physician** Elger Ux Thomas 20 2004 4:20 PM August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimory Wayland

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. NOV 15 1948 Maryland Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **XX**M 2□ F **Funeral** 9. Birthplace (State or Foreign 55 215-52-8922 Yrs Director WAŠHINGTON, D.C Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show r then "neturel", or Items 23e or 28a-f shov Tre Medical Examiner must be notified at MD Director TALBOT OXFORD XXYes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 MARKET ST. 21654 USA death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE à Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "net Importent: other treumetic event, the Medica eng. Elementary/Secondary (0-12) College (1-4or 5+) OWNER/OPERATOR PHOTOGRAPHY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) THOMAS DONALDSON ELGEN POLLY JENKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELISSA M. ELGEN/WIFE 623 SOUTH ST., EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR. 8-22-2004 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHN Z. MERCEROM 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preunoma **Physician** 2 WEEKS /Medical Due to (or as a consequence of): Examiner Years Disease Chronic Obstructive Pulmonny Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 0 2 ER/Outpatient 3FT DOA this funeral 28c. Injury at Work? e Hospitel or Attending Pl 24 hours after death. e Funerel Director: After to 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1- Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 📋 Homicide To the Hospitel within 24 hours a To the Funerel E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) August P16561 20, 2004 iss of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene St. / Baltimore 21201 CINA WILD 31. Date filed (Month, Day, Year) 32. Signature State Registrar

			1 → For State Registrar	State of Marylan		artment of I rtificate of			Reg. No. 0 0 4	28933
Н	Physici	an	Decedent's Name (First, Middle, Last)     —		_			2. Date of Dea	Day Year	3. Time of Death
	/ /Medic	al	Harvey Theodor		Sr.	41. Cit. T	- L tion of D-	August		4:15 P M
	Examir	er	4a. Facility Name (If not institution, give s Frederick Memoria				or Location of Dea	am	4c. County of Dea	
	Funeral		Social Security Number     6. Sex		last birthday)	Frederic		's. 8. Date of Birt	Frederic 9. Bi	K thplace (State or Foreign
	Director			LM 2□F 62		Months Days	Hours Mi	s. 8. Date of Birt (Month, Day March 2	, 1942 Mar	ountry)
	72 hours after death with the Maryland netural', or Items 23e or 28e-f show Alcul Evantiter mast be notified at		10a. State 10b. County	10c. City	y, Town or Lo	ocation				10d. Inside City Limits
	e Mai	ctor	Maryland Frederic	k Thu	rmont					1 ☐ Yes 2 ☐XNo
	ath with the Marylan s 23e or 28e-f show ast be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	ath w	- Fa	7443 Franklinville			217			U.S.A.	
	after dea or Items	Funeral		12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of I If Yes, specify Cub	dispanic Origin? an, Mexican, Pue	(Specify Yes or No- arto Rican, etc.)	14. Race - Am Black, Whi	
36	rs aft	by F	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1∭XYes 2□No Kor IfYes, Give Year or Dates: Vietn		1□ Yes 2🎇 No	Specify:		Specify:	TT. 4 & -
ò	2 hou	ed	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occur	pation		16b. Kind of Business	White Mndustry
215	hin 72	plet	(Specify only highest grade	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of w d)	rorking		,
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p	= = = =	Bec	17. Father's Name (First, Middle, Last)					ame (First, Middle,	Maiden Sumame)	
yla	2 should be and Mental Is marked o	2	George A. Eckenrod	le			Emma Ci	rushon		
Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type	pe, Print)	1				r, City or Town, State,	
	1 and Health em 27 sther tr		Rhea Eckenrode (Wi		7443	Franklin	ville Ro	oad, Thur	mont, MD 2	
0	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	emetery, crei	sition (Name of natory or other pla	ce)		20c. Location - City or	
Baltimore,	nit. Pa bartmen ortant: injury		`4 □Donation 5 □ Other (Specify)	Mt.		ect. Ceme			Lewistown,	
Ba	permit. Pag Department Important: I any injury o once.		21. Sign lun of un ral price	deles fr					ERAL HOMES	
	Pnysician /Medical Examiner		23a. Part1. ENar the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to or s a consequ	uence of):	RIKATI	·	ac or respiratory an	est,	Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Entire Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence).						
P.O. Box 6	that the death certificate led by the attending phys detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	Ideath 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year
	w requires that the sbeen signed by the should be detached	by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use contribute to es 2 ⊠No 3 □ P	o the cause of death?
Vital Records,	The law ate has b page 2 s	Completed	U V	/				24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?					eath (Check only or		
	S S	2	1 195 2 190	1	ER/Outpatier	t 3 DOA	1er: 4 ☐ Nursing		ence 6 Other (Spe	ecify)
n c	After vnera	lon:	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe h	ow injury occurred	
Sic	Attending r death. ector: After by the tune	cat	2 Accident investigation 3 Suicide 6 Could not be	20 Diana of Injury At he			Yes 2 □ No	296 Logation /C	tenat and Mumber of D	
Division of	or At after of Direct	Certification;	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		City or Tow	treet and Number or R n, State)	urai Houte Number,
_	To the Hospitel or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely tilled in by the funeral	edical Ce	29a. Certifier (Check only one)  Certifying Physical Examination (Check only one)	sician: To the best of my knowner: On the basis of examinat	wledge, death	n occurred at the ti	me, date and place	ce, and due to the courred at the time, of	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)
	thin S the mple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		9d. Date signed (Mont	th. Dev. Year)
•	5 7 K 7		1 Km 1 /1	Trackle MO		0.0	1544	-	X13/10/1	
			30. Name and address of person who co	moleted cause of death (tram	239) /T	Print)	21		0/10/03	
	10+1		John A. Vitarello	, MD 180 Tho	mas Jo		ive, Fre	derick, M	D 21702	
	Sta Registr		31. Date filed (Month, Day, Year)  AIIC 3 1 20	32. Registrar's Signa	ture	loo	1			

**ORIGINAL** 

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 = State Registrar			rtificate of	Death	Re	iene •g.No.] [] []	28935
/sicia	an	1. Decedent's Name (First, Middle, Las	,				2. Date of Deat	23 <sup>pay</sup> 2004 <sup>ear</sup>	3. Time of Death 0951 A.
ledic		Charles We  4a. Facility Name (If not institution, give	bster Flow	ers	4h City Town o	or Location of Death		4c. County of Dea	
amin	er	Easton Memorial Ho			Easton	Location of Death		Talbot C	
eral		Social Security Number     6. Security Number		In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreig
tor		219-60-16/9	<b>™</b> 2□ F 5	3 Yrs.	Months Days	Hours Min.	July 26		Maryland
4		Usual Residence of Decedent  10a. State 10b. County	10	0c. City, Town or L	ocation				10d. Inside City Limit
a Dai	jo	DE Susse			Seafo	ord			1 ☐ Yes 2 📉 N
LIGHT	irec	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Co	ountry?
187	alD	2 Brook Haven				19973		U.S.A.	
	Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Si an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	
and and and	by Fi	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:			hite
T S		15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation		16b. Kind of Business	/Industry
Meigh	plet	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wor d)	king		
2	Completed	12		di	esel mech	nanic		poultry p	rocessor
0	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, N	faiden Sumame)	
Dalic	P.	Leonard Webster		405 14-11	4-1 (0)		s Hughes		
any injury or other traumatic event, the Macheal Evant ref must be routing at ODGs.		19a. Informant's Name/Relationship (7 Donna Flowers	wife					City or Town, State, .	Zip Code)
au o		20a. Method of Disposition		20b. Place of Dispo	cook Haver sition (Name of			19973 20c. Location - City or	Town, State
, o		1 Burial 2 □ Cremation 3 □ 1 Donation 5 □ Other (Specify	Removal from State		matory or other place or Memoria		/27/04	Cambridge	MD
2 9		21. Signature neral Service Lies			2. Name and Addres			neral Home	
once		I follows I	mon	-	700 Locus				
cal			a	CHEVIC	Carduvas	auar l	rsuse		
ner	sal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	onsequence of).	<u>Curanyas</u>	war t	isase		
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		Decedent's Name (First, Middle, Last)						2. Date of Dea	th	, 111,	- 0	3. Time of Death
Physici /Medi		Maria Cecelia Magalong H	is	ter				08/25/2	004	у Үө	ar	10:42 P M
Examir		4a. Facility Name (If not institution, give street and number)				Location of				. County of D		
		Ft. Washington Hospital				hingt				rince		
Funeral Director		5. Social Security Number  217-98-8292  Usual Residence of Decedent	hday) (rs.	If Under Months	Days	If Under	Min.	8. Date of Birth (Month, Day 12/22/1	967	9. Ph	Birthola Count 111	ace (State or Foreign ry) .ppines
land ow		10a. State 10b. County 10c. City, Town	or Lo	cation							10	d. Inside City Limits
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23a 23a	by Funeral Director	11402 Gunpowder Drive			2074	4				USA		
ar dea	nuel	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - A Black, W		
s afte	Y F	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1□Yes a		Specify:				Specify: F		_
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portition of the proof of the control of the control of the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28e-1 show appringury or other traumatic event, the Medical Exactive transitival control once.		Querubin Fister / Father 114	<sub>+</sub> 02	Gunp	owde:	r Dri	ve F	t. Wash	ing	ton, M	э, <i>Zip (</i> D <b>.</b>	<sup>20de)</sup> 20744
of He or oth		20a. Method of Disposition  20b. Place of cemeter  20c. Place of cemeter	Dispo	sition (Nam natory or of	ne of ther place	)				ocation - City		
Pag ment tant:		`4 □Donation 5 □ Other (Specify)										Maryland
permit. Pages Department of Important: If it any injury or o		21. Signature Funeral Service Licensee	22	Name and	d Address	of Geo Hill	rge Roa	P. Kala d Oxon	s Fi	uneral l, Mar	Ho vla	me P.A. nd 20745
		23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.									1	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	IIA	7							(	Onset and Death
/Medical Examiner	П	resulting in death)  Due to (or as a consequence of										
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w require been sig should b		CEREBRAL PALSY						1 ☐ Ye	s 2	<b>⊘</b> No 3□	Probat	oly 4 □Unknown
e lawr has be	Completed	,						24a. Was ar				sy findings available pletion of cause of
The The ate h	Con							perform	ied? ⊠No	death 1 🗆 Y	?	□ No
hysician: The land is certificate had director, page 2	Be (	25. Was case referred to medical examiner?					of Death	(Check only on	e)			
Physi this a	Ţ	1 ☐ Yes 2 № No Hospital: ☐ Inpatient 2 ☐ ER/Out  27. Manner of Death 28a. Date of Injury 28b. Ti				4 LI Nui		ne 5 ☐ Reside			oecify)	
ding h. After funer	tion	1 Natural 5 Pending (Month, Day Year) In	jury	м 28	Bc. Injury Work	at ? es 2 ∐ N		8d. Describe ho	w injur	y occurred		
deat deat ctor: y the	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, far	m. stre					8f. Location (Sti	eet an	d Number or	Rural F	Route Number
a after	erti	4 Homicide determined building, etc. (Specify)		,				City or Town				,
To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifice completely filled in by the funeral director, r	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death Vor inv	occurred a restigation,	t the time in my opi	e, date and inion, deat	d place, a	nd due to the ca	use(s) ite and	and manner place, and d	as stat ue to ti	red. he cause(s)
To the Within Fo the	Me	29b. Signature and title of certifier PHY SICIAN		29c.	License	number		29	d. Date	e signed (Mo	nth, Da	ay, Year)
r- > 0				Î	000	537	82		1	Anu G	26	the 2004
CR (5)		30. Name and address of Person who completed cause of death (Item 23a) (1701 LIVING-STON ROAD; SU	Type,	Print) Su	resh	Verg	hese	, M.D.	NG-7	on.	M	D
Sta		31. Date filed (Month, Day, Year) 22. Registrar's Signature			101	/_	<i>,</i>	7-113/11	-			
Registr	ar	AUG 3 0 2004 Black & A	24	V.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 2:25pm 2.2 hirle 2004 Hugust /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charle 3950 Northquite WalderT lace If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours 1 M 2 South Carelina 5 578-66-1555 Director Sopt-16, 1950 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Charles Ma. Waldort 1 Yes 2 No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20602 USA 3950 or Items 23a Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No f Yes, Give Year or Dates: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene, Important: If itam 27 ie markad other than any injury or othar traumatic event, Ita Ma 00ce. Elementary/Secondary (0-12) College (1-4or 5+) aretaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Doug Marvella 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) tuslainel Waldert 02 14116 6 20b. Place of Disposition (Name of cometery, crematory or other place)
Resurrection lemekay 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Facility Washington DC 2003 1813 Peternae Ave Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Ischemic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy į Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 14No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only open examiner? Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 Musidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗷 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Diractor: A 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) 1200550883 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. NRSUD

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

31. Date filed (Month, Day, Year) AUG 3 0 2004

11655

. Registrar's Signature

PL

MD

		For Stete	State of Maryland	•			lental Hyg	jiene	
	_	Registrar  1. Decedent's Name (First, Middle, Last)		Cert	tificate of I	Death	2. Date of Dea	leg. No. 2	3. Time of Death
Physic	ian	1. Decedent's Name (First, Middle, Last)	SREEKE				Month (	Day Yea	
/Medi	cal	1 DA ROPERIA	9.00		4h City Tours or	Location of Death	08	4c. County of De	
Exami	ner	4a. Facility Name (If not institution, give	11 .// /	enter	46. City, Town, or	Location of Death		4c. County of De	eath .
		5. Social Security Number 6. Sex	1030000	- / -1	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	1,01	Birthplace (State or Foreign
Funeral Director	ŀ.		M 2027F 63	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Dec . 24	Year) 1940 Ma	rvland
		Usual Residence of Decedent	- 05				DEC.24	,1740   Ma	Lyland
yland		10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
Mar B-1 s	tor	Maryland Queen Ann	ne Ch	estert	own				1 □Yes 2. PNo
n the	Directo	10e. Street and Number			10f. Zip Code		1	l 0g. Citizen of What	Country?
th will		1204 Ewingtown Ro	oad		21620			USA	
dea dea	Funeral		12. Was Decedent Ever in U.S Armed Forces?	3. 13. W	/as Decedent of H Yes, specify Cuba	ispanic Origin? (Sp In, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ar Black, W	nerican Indian,
within 72 hours after death with the Maryland within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-1 show he Mcdical Examinar must be notified at		1 Never Married 2 Married	1 ☐ Yes 2 17 No If Yes, Give		☐ Yes 201 No	Specify:	The state of the s	Specify:	1110, 010.
72 hours "natural",	d by	3 Widowed 4 Divorced	Year or Dates:						Black
be filed within 72 hours af ital Hygiene. Id other than "natural", or event, the Medical Exam	Completed	15. Decedent's Edu- (Specify only highest grade		(Give k	ent's Usual Occup kind of work done o O NOT use retired	during most of work	ing	16b. Kind of Busines	ss/Industry
hen.	m d	Elementary/Secondary (0-12)	College (1-4or 5+)						
0 0 0	ပိ	17. Father's Name (First, Middle, Last)	3	Lin	e Worker	18. Mother's Name		Campbell :	Soup Co.
Mal y lail with a file of 2 should be file the and Mental Hy 27 is marked oth traumatic event	Be							_	
should be nd Menta marked umatic ev	2	Unknown	Ovi-M	10h Maille	A ddr (O			Greene r. City or Town, State	7.0.43
C, Mal y ic s 1 and 2 should f Health and Mer tiem 27 is marke		19a. Informant's Name/Relationship (Ty)			,				
ne ag	1 13	Wanda Rowence Robe	ertson/daugnte	T 1U4 ace of Dispos	Last Loc ition (Name of			Middletor 20c. Location - City	
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t. Pa	H	`4 ☐Donation 5 ☐ Other (Specify)	Ri				//2004	Ewingtown	Maryland
partilliore, permit. Pages 1 a Department of Hea Important: If item any injury or othe	_	21. Signature of Funeral Service Lice	~	B	ennie Sm	ith Funer	al Home		ware 19904
- 402 60		1 2 4 1	- A' Al A						
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death. ne cause on each line.	Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
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/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):				•	
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ecution and -tran	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
icate be executed physician and the burial-transit	E E		Due to (or as a conseque	61 ICO OI).					
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se as	Me	IF FEMALE:	3c. If yes, outcome of pregnan	101					
death certifi e attending i	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal	death 3 ⊡8	Ectopic pregnancy			23d. Date of d Month	lelivery Day Year
. 0 00	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	atn 5	Other (specify)				
law requires that the as been signed by the 2 should be detached.	P.	Part II, Other significant conditions con	tributing to death but not resul	ting in the un	deriving cause give	en in Part I	23e. Did tol	pacco use contribute	to the cause of death?
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he law requir h has been si ige 2 should I	ldu						24a. Was a autops	y prior to	autopsy findings available of completion of cause of
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Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?			-	26. Place of Deati	n (Check only on	e)	
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I or Attending after death. Director: After	Certification;	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No			
or Atten after deati Director;	T.	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (St City or Town		Rural Route Number,
spital or ours afte	S		1						
하는 기 등	edical	(Check only 2 Medical Examin	sicien: To the best of my knowner: On the basis of examination	vledge, death on and/or inve	occurred at the time estigation, in my op	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner a ate and place, and di	as stated. ue to the cause(s)
To the I within 2 To the I complet	Med	one)	and manner stated.		29c. License	number		9d. Date signed (Mo	nth Day Vear
To With		29b. Signature and title of certifier	N. A		Zac. License	/ / / / 7	2	Del - /	an, Day, real)
		1 Kollin	n, 1000	•	0	213		01/1/6	4
		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, R	Print)	1,0.100	77	10	02620
		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	anun	you /1	or / Ch	ester	oun M	0 4620
St Regist	ate rar	Alic 23		A .	dods				
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			1 - For State Registrar	State of N	laryland / Dep <i>Ce</i>	artment of F		-	giene Reg. No.	004	28939
	Dhysici		Decedent's Name (First, Middle,	Last)				2. Date of De.	ath		3. Time of Death
	Physici /Medi		Beulah	Virginia	Greever			Aug	29.	2004	12:10A.
	Examir	er	4a. Facility Name (If not institution, g		r)	4b. City, Town, or	Location of Death		4c. Co	ounty of Death	
			Layhill Center  5. Social Security Number 6		A (1 1- A 1 int 1 )	Silver	Spring	11-1		ontgome	
	Funeral Director		577-226-6946	.Sex 7. A 1 ☐ M 2 🛣 F	Age (In yrs. last birthday)  83  Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	/, Year)	Cou	place (State or Foreign intry)
			Usual Residence of Decedent		03			Dec.6,	1920	WV	
	nylan how		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	e Ma	ctor	MD Montg	omery	Silver	Spring					1 ☐ Yes 2 No
	라 라 67.28	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Cou	ntry?
	ath v	rai	3227 Bel Pre R			20906			USA		
	ltam:	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder	>:	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,	
99	urs af	by F	3 ☐ Widowed 4 ★Divorced	1 ☐ Yes 2 If Yes, Give Year or Dates	: .	1 ☐ Yes 2/CXNo	Specify:		Sp	pecify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. Then "natural", or Itams 23a or 28a-f ehow Ite Marical Examinating and the notified at	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occupa	ation		16b. Kind	of Business/Ir	ndustry
2	thin 7	npie	(Specify only highest of Elementary/Secondary (0-12)	College (1-4o	life.	kind of work done of DO NOT use retired	during most of work ()	king			
7	ed wi ygien narth t. Ite	Completed	12			borer			Mari	ciott C	Corporation
힏	be fill ital H id oth	Be	17. Father's Name (First, Middle, La	st)			18. Mother's Nam	e (First, Middle,	Maiden Su	mame)	
<u>\Z</u>	d Mer narke	2	Alonzo C. McC				Elta F	Wolfe			
Maryland	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship			ng Address (Street a					
ā,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Beauthorath: I firem 27 is marked other than "natural; or Itams 23a or 28a-1 ehow any injury or other traumatic evant. It is Marical Examination as to notified at once.		Barbara J. Cotto	one (daugn	20b. Place of Dispo	Cove Cir		04 St.I	eters	burg,	FL 33708 own, State
ltimore,	Pages nent of h ant: If its ury or of		1 Burial 2 Cremation 3		e cemetery, crer	natory or other place	<sup>e)</sup>   9/1.	/04			
alti	ortar injur		21. Signature of Fineral Service Lice		_ Omps Cre	mation Se	rvice is of Facility			ester,	
ä	Depa Impo any ir		1 Carries +	1 - 18		McKee Fun		e In.c		O. Bpx	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	ed the death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arr	est,	ca, w	Approximate
F	nysi <b>ci</b> an	s o	Immediate Cause (Final disease or condition		ailure to Th	0.00					Interval Between Onset and Death
	/Medical		resulting in death)		s a consequence of):	ictve					few months
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7	sit a	iner	rt any, leading to immediate cause. Enter Underlyin	Due to (or a	s a consequence of):						_years
	and I-tran	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):						
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	phy:	edicai		d							
Вох	e attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy				23d	Date of delive	201
m i	death e atte	icla	in the past 12 months?	4 Pregnant a		Ectopic pregnancy Other (specify)			200.	Month	Day Year
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ر ن	ine law requires mat me ite has been signed by th bage 2 should be detache	by	Part II. Other significant conditions	contributing to death	but not resulting in the ur	nderlying cause give	n in Part I.	23e. Did tol	acco use	contribute to th	ne cause of death?
ord	been signatures	ted	Chronic Obstr	uctive Lun	g Disease —			1 🗆 Ye	s 2 N	o 3 Prob	ably 4 Unknown
Records,	as b d sar d sar e 2 st	ompieted						24a. Was a		4b. Were auto	psy findings available impletion of cause of
		Con						perform		death?	
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ō	this rald	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpati 28a. Date of Inj		The second secon	4X Nursing Ho	me 5 Reside			1)
	After funera	tion	1 X Natural 5 ☐ Pending	(Month, Da	ury 28b. Time of Injury	28c. Injury Work M 1 □ Y	at ? ′es 2 ⊡No	28d. Describe ho	w injury oc	curred	
Division	after death. I Diractor: After din by the funer	ertification;	3 Suicide 6 Could not	be One Diese of le	njury - At home, farm, stre			28f. Location (St	reet and Nu	umber or Rura	I Route Number
_ ;	- e.e.	Certi	4 Homicide	building, e	ic. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Towr	, State)	-11207 07 71270.	Tiouto Multiper,
9	hours unera ly fille	Sai	29a. Certifier 1 Certifying F	Physician: To the best	of my knowledge, death	occurred at the time	e, date and place,	and due to the ca	use(s) and	I manner as st	ated.
1	within 24 hours af To tha Funeral D completely filled is	ledicai	(Check only 2 Medical Expone)	aminer: On the basis of and manner s	of examination and/or inv	estigation, in my op	inion, death occurr	ed at the time, da	ite and pla	ce, and due to	the cause(s)
Š	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	$\cap$	0.5	29c. License		2		gned (Month, I	
			Honen	Alle	200 m	D382	262		Aug.	30, 20	004
	1		30. Name and address of person who			1					
	Š		Dr. Anvrita Men 31. Date filed (Month, Day, Year)	dhiratta	2401 Resear	ch Blvd.	Suite 33	0 Rocks	ville.	, Md.	
	Sta Registra		SEP 1 0	2004	en le	horte					

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Month 11:18 A<sup>M</sup> DONALD HOBBS September 6, 2004 LEROY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month Day, Year) ADY 22, 1932 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 214-34-9641 1**X** M 2 □ F Mary Land 72 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show itam 27 is marked othar than "natural", or itams 23a or 28a-1 sho: other traumatic evant, the Medical Examinar must be notified at Maryland Frederick Frederick 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8107 Arrowhead Court 21702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡X'es 2 □ No 1949 − If Yes, Give Year or Dates: 1953 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or iter any njury or other fraumatic evant, the Medical Examina 0068. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Service/Installation Dairy Equipment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pau1 Andrew Hobbs Ada 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8107 Arrowhead Court, Frederick, Maryland 21702 Mrs. Patricia Stone Hobbs/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Olivet Cemetery Sep 10,2004 Frederick, Maryland \* 4 ☐ Donaţion 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 21. Signatur of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and/Death Immediate Cause (Final en stive Physician 40x disease or condition resulting in death) /Medical Due to (or as a nsequence of): Examiner 10 your Sequentially list conditions, if any, leading to infine data cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit that initiated events certificate be exec resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physiclan/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe artinian's Differto 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After t 1. Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dirac 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D09689 ritim 1011VL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austin Pearre, Jr, M.D., 300 West Ninth Street, Frederick, Maryland 21701 31. Date filod (Month, Day, Year) 32. Registrar's Signature State SEP 1 3 2004 Elem & fresh Registrar

DELIVER 11 1164 1/2001

			1 - For State Registrar	State	of Maryla	and / Dep <i>Ce</i>	artment <i>rtificate</i>			nd M		giene	OOL	2891.3
	Dhusisi		1. Decedent's Name (First, Middle,	Last)							2. Date of De	ath		3. Time of Death
	Physici /Medio		Ruth Jar	ie	Isen	berg					Aug 28	Day 20	04	2:55 P.M.
	Examin		4a. Facility Name (If not institution,				4b. City, To	own, or	Location of	Death		4c.	County of Dea	
			2600 Keat						Hills					George's
	Funeral Director		5. Social Security Number 215 20 3642	3. Sex 1□ M -2□ F		rs. last birthday, Yrs.	If Under 1 Months I	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	v. Year)	1 6	nthplace (State or Foreign ountry)
			Usual Residence of Decedent		78						April	19,	1946 M	aryland
	yland		10a. State 10b. County		10c.	City, Town or L	ocation							10d. Inside City Limits
	Marined	tor	Maryland Prince	George	's	Temp1e	Hills							1 ☐ Yes 2 ☐ No
	th th or 28	Director	10e. Street and Number			•	10f. Zip C					10g. Citi	zen of What C	
	23a		2600 Kea	ting St	reet Ap	t 209	20	748				J	Jnited	States
	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28a-f show then "naturel" or items 23a or 28a-f show ite Madical Examiner must be notified at	by Funeral	11. Marital Status	Armed F		U.S. 13.	Was Deceder	nt of His	spanic Origi	in? (Spe Puerto f	cify Yes or No Rican, etc.)		14. Race - Am Black, Whi	
36	s afte	Ϋ́F	1 ☐ Never Married 2/7/Marrie 3 ☐ Widowed 4 ☐ Divorced	11 105.0	Sive XXVo		1□ Yes 2		Specify:		,	-	Specify:	
8	hour turel		15. Decedent's	Year or	Dates:		21.						W	hite
5	in 72 in na	Completed	(Specify only highest	grade completed	·	(Give	dent's Usual ( kind of work DO NOT use	done di	urina most i	of workin	19	16b. Kii	nd of Business	/Industry
212	with jiene. r the	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)	_	cretar					Parc	10 8.Dr	obation
b	illec I Hyg othe	Be C	17. Father's Name (First, Middle, Li	ist)			CICCUI		18. Mother	's Name	(First, Middle,			Obacion
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Importent: If item 27 is marked other then "naturel; or items 23a or 28a-f show any injury or other treumatic event, the Modical Examiner must be notified at ones.	To B	Joseph Sute								ine Per			
Mar	d 2 sh th and th and 7 is m treum		19a. Informant's Name/Relationshi David W. Isent		(Husban	19b. Maili d) 2600	ng Address (S Keati	ng S	nd Number Street	or Rural	Route Number	r, City or	Town, State,	Zip Code) 1 c MD 20748
ē,	Heal Heal Hem S		20a. Method of Disposition		20b	. Place of Dispo	sition (Name	of	1		ate .		cation - City or	
Baltimore,	Page ent o nt: If ry or		1 Delurial 2 Cremation 3		n State R	esurrec				Sent	2 2004	C1 i	nton	Maryland
Ħ	mit. Dartm Sorte	1	21. Signature of Funeral Service Li											c 6633 01d
m	Depariment Department of the sany ir		Tonis File	trant.	m0023									nd 20735
			23a. Part 1. Enter the disease, or c shock, or heart failure. List of	omplications that	caused the de	eath. Do not en	ter the mode o	of dying	, such as ca	ardiac or	respiratory ar	rest.		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		1	1100	ſ	A	010	1				Onset and Death
п	/Medical Examiner		resulting in death)	Due to	o (or as a cons	equence of):	1	12						1300
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	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Dueto	J (OI as a COIIs	equence on):								
Ć.	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a cons	equence of):								
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о. П	the at	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4∐Preg 9⊟Unki	gnant at time of nown		Other (speci						Month	Day Year
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Vital		ပိ	25. Was case referred to medical						00 Dlass	4 Danib		2 No	1 🗆 Yes	2 No
>	8 0 E	OB	examiner? 1 ☐ Yes 2 🙀 故 o	Hospital:	Inpatient 2	ER/Outpatier	it 3 DOA	Other			(Check only or		□Other (Spec	-4.1
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0	uttendin death. ctor: Afi y the fur	atlo	XXNatural 5 ☐ Pending 2 ☐ Accident investiga	tion	mi, Day 19ai)	Injury	M		es 2 □ No					
Division of	i or Attendater death after death Director: I in by the	Certification;	3 Suicide 6 Could no 4 Homicide determin	ad 286. Plac	e of Injury - At	home, farm, str	eet, factory, or	ffice		28	If. Location (S City or Tow	treet and	Number or Ru	ıral Route Number,
	oitei o urs af erel D		****								-			
	To the Hospitei or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel	edical	29a. Certifier 1 X Certifying (Check only 2 Medical Exone)	Physician: To th aminer: On the l and mar	ne best of my ki basis of examil nner stated.	nowledge, death nation and/or in	n occurred at t vestigation, in	my opii	, date and p nion, death	place, ar occurred	nd due to the c d at the time, o	ause(s) a late and p	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		1.) 1		29c. L	icense	number		2	9d. Date	signed (Month	h, Day, Year)
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P	RE	1	30. Name and address of person wh					.,						
1	Sta		Barry Redjae	e, M.D.	446 / UJ Resistrar's Sign			#2	01, T	emp1	e Hills	s, MI	20748	
	Registr		SEP 0 1	2004	Deve	1. 19	peril							

		,	1 - For State Registrar	State of Ma	ırylan	d / Depa		t of H	ealth an		Hygiei Reg.	ne 2001	1 4	28944
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Later Roy Ernst  4a. Facility Name (If not institution, give Buckingham's Cho	e street and number)		ensen ce Ctr		Town, or	Location of D	2. Date of Month Septe	ember	2, 200 4c. County of I	Death	3. Time of Death 1040am M
4	Funeral Director		5. Social Security Number 6. S 578-44-5169	ex 7. Age	(In yrs. 96	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min. 8. Date of (Monti	f Birth b, <i>Day</i> , <i>Ye</i> 3, <b>1</b> 9	ar) 9. 08 Ca	Birthpla Countr alif	ace (State or Foreign ry) ornia
	le Marylend Be-f show diffed at	ctor	10a. State 10b. County Maryland Freder	rick	10c. Cit	y, Town or Lo Adar	cation nstown	n						d. Inside City Limits 1 ☐ Yes 2 XNo
	3a or 2	i Dire	3200 Baker Circle	2			10f. Zip		<b>71</b> 0		10g.	Citizen of Wha		ry?
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other treumetic event, the Medical Exam are must be troubled at ODGe.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:			Was Deced f Yes, spec		spanic Origin n, Mexican, F Specify:	? (Specify Yes o uerto Rican, etc	r No-	14. Race - A Black, N Specify:		tc.
Maryland 21215-0036	in 72 ho n "natur dedical	To Be Completed	15. Decedent's Ed (Specify only highest gra	de completed)		16a. Deced (Give life.	lent's Usua kind of wor DO NOT us	al Occupa rk done d se retired,	ition luring most of	f working	16b	. Kind of Busin	ess/Indu	ustry
212	filed with Hygiene other thai	Com	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5-	+)	Engin	eerin	g &	Manage	ement Name (First, Mi		oad/Hig	hway	7
/lanc	should be find Mental Harked of	To Be	Mathias		gens	sen			Anna	Name (First, Mi	Mari		eeb	erg
Man	nd 2 sho lith and I 27 is ma		19a. Informant's Name/Relationship (I							or Rural Route N YS <b>town</b> ,				
ore,	Pages 1 and nent of Health snt: If item 27 ury or other to		20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 □	Removal from State	20b. P	lace of Dispo emetery, cren	sition (Nam	ne of ther place	9)	Date		Location - City		
Baltimore,	permit, Page Department of Importent: If any injury or once.		* 4 □ Donation 5 □ Other (Specify 21. Signatury of Funeral Service Licent	1	Smı	thsbur,	g Cre .Name an	mato <sub>d Addres</sub>	ry Sep	3, 200	4 Smi	thsburg	g, M	Maryland
	Physician /Medical		23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each lin  a. Pneumoni  Due to (or as a	•. .a (t	oilater		ey ox st Ch e of dying	DASTO	rd P.A. St, Fred diac or respirato	rune: eric ry arrest,	ral Hom k, Mary	1	A 21701 Approximate Interval Between Onset and Death Week
3760,	rate be executed with the burial-transit the burial	licai Examiner	Sequentially list conditions, 1 any, leading to instruction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Renal In Due to (or as a c. Dementia d.	Lew	aunce of: rys boo								months year
.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the 19 □ Unknown	2 🗌 Fetal	death 3	Ectopic pre Other (spe					23d. Date of Month		ay Year
ds, p	uires that the de signed by the a ld be detached f	by	Part II. Other significant conditions of Hypoalbuminemia	ontributing to death bu	t not resu	ulting in the ur	iderlying ca	ause give	n in Part I.					cause of death?
Il Records,	. The law requires that the cate has been signed by th page 2 should be detache	Completed								— a	Vas an utopsy erformed? es 2 XI	prior deat	to comp	y findings available detion of cause of
Division of Vital	ding Physician: Th h. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatier 28a. Date of Injun (Month, Day		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	r: 4X Nursir	Death (Check or ng Home 5 🗆 F 28d. Descr	lesidence	6 □Other (S	Specify)	
Divisi	el or Attending s after death. I Diractor: After d in by the fune	Certification:	3 Suicide 6 Could not be determined		ry - At ho (Specify	me, farm, stre	eet, factory,				n (Street Town, Sta	and Number or ate)	r Rural F	Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medicai (	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of niner: On the basis of and manner stat	examinat	wledge, death ion and/or inv	occurred a estigation,	at the time in my op	e, date and pi inion, death o	lace, and due to occurred at the ti	the cause ne, date a	(s) and manner nd place, and	r as state due to th	ed. ne cause(s)
	To th within To th	Me	29b. Signature and title of certifier	Keill	4.	ML	7	License D 54				oate signed (M		
	.1		30. The and address of person who of	completed cause of d	th (Item	23a) (Type, 8	Print)			2	-		•	
	Sta		J. Allen Reilly, 31. Date filed (Month, Day, Year)	22 Rodetra	r'e Signat	tura		-	D-1, F	reaeric	k, Ma	ryland	21/	01-6111
	Registr	ar	SFP 1 3 2	2004	40.0	K A	harte							

		1 - Stata RegistraAMEND ITEM ; 1. Decedent's Name (First, Middle, Las	st)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	704(02)	Dodin		2. Date of Dea		Vaer	3. Time of Death
Physici /Media		Cassandra Ja	ckson						Month O8	2 <sup>Day</sup> 2	2004	11:25pm
Examir		4a. Facility Name (If not institution, give				b. City, Town,					ty of Deeth	0.77.7
		13510 Duhart 1 5. Social Security Number 6. S		ne (In vrs. Is	ast birthday)	Ge I If Under 1 Year	rmant		8. Date of Birth	1	ntgom	_
Funeral Director				32		Months Days		Min.	8. Date of Birth	- <del>Y</del> 92')	Ma	place (State or Foreigntry) ryland
yland sow		10a. State 10b. County		1	, Town or Loca						1	I Od. Inside City Limit
e Mar	ctor	Md Montgo	omery		German							1-16 Yes 2□N
with th	Funeral Director	10e. Street and Number 13510 Duhart	Road			10f. Zip Code 2087	7 4		1	10g. Citizen o US		ntry?
death	nera	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	6. 13. Wa	as Decedent of	Hispanic Original	gin? (Spe	ecify Yes or No- Rican, etc.)	14. R	ace - America	
within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show its Medical Exercites resal be notilied at	by	1 【X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No		Yes 🛣 No				Spec		lack
72 ho natur	eted	15. Decedent's Ed (Specify only highest gra	ducation de completed)		16a. Deceder (Give kii	nt's Usual Occu nd of work done NOT use retir	ipation during most	t of worki	ng	16b. Kind of		dustry
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any idepty or other traumatic event, the Medical Examiner must be notified at once.	To Be Co	17. Father's Name (First, Middle, Last) N/A							(First, Middle, Widema		ame)	
2 should and Men is marke reumatic	-	19a. Informant's Name/Relationship (							Route Number			
1 and Health em 27 ther tr		Felicia Jacks 20a. Method of Disposition	son Si	ster	ace of Disposit	ion (Name of			ermanto	20c. Location		
ment of h		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specif	y)	Jei	rsalem	tory or other pl		8/2	28/04	Poole	svil	le,Md
permit. Pag Department Importent: I any intervo		21. Signature of Funeral Service Licer	9	C.	5	732 G	eorgi	a Av	re NW W	lashir		Servic, DC 200
Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to (or as	a consequ	ence of):	Î ve	vere	Co	free	8 T		Interval Between Onset and Death
le be executed ysician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	eus	we i	Recu Fric	Cer	CR VCC	Non	Cera	nex	
irres that the death certificale be executed signed by the attending physician and be detached for use as the burial-transit	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ¶o 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3□E	ctopic pregnan Other (specify)	су			i	Date of deliver	ery Day Year
uires that signed b	d by Pi	Part II. Other significant conditions of	contributing to death t			erlying cause g	iven in Part I.	· · · · · · · · · · · · · · · · · · ·	23e. Did to			ne cause of death?
Physician: The law requires that the death this certificate has been signed by the atterral director, page 2 should be detached for u	omplete								24a. Was a autops perform	sv	prior to co death?	ppsy findings availal mpletion of cause of
	0	25. Was case referred to medical					26. Place	of Death	(Check only or		10 163	20110
Physician: this certific ral director,	ToB	examiner? 1 🗆 Yes 2 🔼 No	Hospital: 1 ☐ Inpati	-	VOutpatient	3LI DUA		irsing Hor	ne 5 Seside	ence 6 🗆 O	ther (Specif	y)
Attending PI r death. ector: After th by the funeral	atlon:	27. Manner of Death  Table Natural  5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	ay Year)	28b. Time of Injury	28c. Inji W M 1 [	uryat ork? ∐Yes 2 ☐ I		28d. Describe h	ow injury occi	urred	
at e e e e	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of in	jury - At hor tc. (Specify		t, factory, office	9	2	28f. Location (S City or Town		nber or Rura	al Route Number,
tel or A s after el Dire ed in by	-		ysician: To the best niner: On the basis	of examinati								
P Hospitel or A 24 hours after Funerel Directely filled in by	dica	one)	and manner s									
To the Hospitel or A within 24 hours after to the Funerel Directorpletely filled in by	Medical		and manner's	7		29c. Licer	nse number		2	9d. Date/sign	ed (Month,	Day, Year)
To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medica	one)	My	) 2		B	nse number 7808	30	2	29d. Date sign	ned (Month,	Day, Year)

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			5	tate of Marylar		tificate of		vientai Hygie Reg.	000	11. 2001 6
			Decedent's Name (First, Middle, Last)			invocato or	- Doutin	2. Date of Death		3. Time of Death
	Physici /Medio		Tyree Donye		Kins	70	,	08 0	23 0	794 1555
7	Examir	er	4a. Facility Name (If not institution, give stree	1	( de )		4b. City, Town, or L		4c. County o	Death
	Funeral		Memorial Hospi 5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.			9. Birthplace (State or Foreign Country)
ı	Director		NIA IM	2□ F	Yrs.	Months Days	Hours Min.	08-23	04 /	Yaryland
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Loc	cation				10d. Inside City Limits
	e Man	ctor	MD Dorches	Her Co	ambe	ridge				1 2⊠Yes 2 □ No
	with th	Funeral Director	10e. Street and Number	DI		10f. Zhe Code	613	10g.	Citizen of Wh	net Country?
	death	neral	11. Marital Stetus 12. V	Vas Decedent Ever in U	,S. 13. <u>V</u>		Hispanic Origin? (Span, Mexicen, Puert	pecify Yes or No-		- American Indian,
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examinat rrust be notified at once.	þ	1 Married 2 Married 1	Armed Forces?  Yes 2 No f Yes, Give fear or Dates:		Yes, specify Cub		o Rican, etc.)	Specify:	Black
5-0	"natur	eted	15. Decedent's Educatio (Specify only highest grade cor	n npleted)	16a. Deced	ent's Usual Occup kind of work done	pation during most of word d)	king 16b	. Kind of Bus	iness/Industry
21215-0020	withir iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ille. D	NOT USE PETITE	ia)		NIA	3
	e filed w al Hygier I other th vent, the	Be C	17. Father's Name (First, Middle, Last)		J	/\//	18. Mother's Nan	ne (First, Middle, Maid	den Sumame,	^ ^
Maryland	should but marked umatic e	To	Tyree Donyell	JENKIN	_	10.	Koshau	0 0	Tyke	
	and 2 sh ealth and n 27 is n	6 8	19a. Informant's Name/Relationship (Type, F					ral Route Number, Ci BRIDGE, MD		tate, Zip Code)
Ze,	es 1 ar of Hea of Hea item?		20a. Method of Disposition	20b. F	lace of Dispos	sition (Name of etory or other pla				ity or Town, State
altimore,	Pages ment of I ant: if ite jury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	vai from State	-			8-25-2004	STEVE	NSVILLE, MD
Ba	permit. Pag Department Important: i any injury o	r d	21. Signature of Funeral Service Licensee	FRIER	FE		ELFENBEIN	& NEWNAM EASTON, M		AL HOME PA
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ns that caused the deat	_					Approximate Interval Between
<i>j</i>	Physician /Medical		Immediate Ceuse (Final	0	. 1					Onset and Death
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68760,	rificete be executed ng physician end as the bunal-transit	edical	cause. Enter Underlying Cause Diseese or injury that initiated events resulting in death) Last	Due to (o	r as a consequ	ence of):				
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J.	that the der	Physiclan/M	Part II. Other significant conditions contribu	ling to death but not res	uiting in the un-	denying cause gi	ven in Part I.	23b. Did tobac		ibute to the ceuse of deeth?
- S	8 5 8	ρ		-						041. 144
Records,	v require been sig should t	Completed						24a. Wes an au performed	itopsy ?	24b. Were autopsy findings eveilable prior to completion of cause
ě	he lav te has age 2	omo						1 ☐ Yes	2 <b>D</b>	of déath? 1 ☐ Yes 2 ☐ No
		Bec	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)		
0	- = o	ဍ	1 ☐ Yes 2 ☐ No Hospii	1 25 Inpatient 2 🗆	ER/Outpatient 28b. Time of	3LI DOA		ome 5 Residence		
5	Attending Physicien: sr death. ector: After this certific by the funerel director,	tion	1 Matural 5 Pending 2 Accident investigation	Ba. Date of Injury (Month, Dey Year)	Injury	28c. Injui Wo M 1 □	rk?  Yes 2□No	28d. Describe flow in	njury occurred	
Division	2 4 4 2 €	Certification:	a Cuisida 6 Could not be	Be. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (Street City or Town, St		or Rurel Route Number,
_	To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edicai C	29a. Certifier (Check only one)  1 Certifying Physicler 2 Medical Exeminer:							
	To the within To the comple	Me	29b. Signature and title of certifier	/M.S		29c. Licens	se number	29d.	Date signed (	Month, Day, Year)
			30. Neme end address of person who comple	ted cause of death (Item	23a) (Type, P	Print)	1 1	- 18	1001	07
			Michael Judd 31. Date filed (Month, Day, Year)	504 232. Registrar's Signa	Td!	ewild	HVe.	Easton	), M1	21601
	Sta Registr		AUG 25 2004	Box A.	Spark	U				

DHMH 16 Rev 6/95

Samantha M. Johnson 04-5550 DOS

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4-5 OS	550	_	1 - State Registrar	State of Maryland	d / Depa		t of He	ealth an	d Mental		ne 200	4 2 R	91.7
	Physic /Medi Exami	ical	Decedent's Name (First, Middle, Last)     SAMANTHA MARIE     Aa. Facility Name (If not institution, give str     Near 1400 Dun Swat					Location of D Oke Ci	Augu eath	st 27		ear 150 Death	e of Death
	Funeral Director		5. Social Security Number 6. Sex 213-21-9854 Usual Residence of Decedent	7. Age (In yrs. Ia	ast birthday) 6 Yrs.	If Under Months	1 Year Days	If Under 24   Hours N	Hrs. 8. Date (Mont) 3/24	of Birth h, Day, Yea 1/1988	9.	Birthplace (Sta Country) Marylan	te or Foreign d
	the Maryland 28a-f show cuiting at	ector	10a. State 10b. County  MD Worceste  10e. Street and Number		, Town or Lo	e Cit						1 🕸	e City Limits Yes 2 □ No
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evantionary to other traumatic event, the Medical Evantionary and the redifficed at 2006.	d by Funeral Director	712 Tenth Street,	Apt. 207  Was Decedent Ever in U.S Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	11		851 ent of His rfy Cuban	panic Origin? , Mexican, Pi Specify:	(Specify Yes ouerto Rican, etc.			American Indian White, etc.  white	
nd 21215-0036	e filed within 72 h al Hygiene. other than "natu vent, the Meulca	Be Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 1 0  17. Father's Name (First, Middle, Last)	completed) College (1-4or 5+)	16a. Deced (Give life. L studer	kind of worl OO NOT use	k done du e retired)	iring most of	working Name (First, Mi		Kind of Busin	ess/Industry	
Maryland	2 should be and Menta is marked aumatic even	To E	Anthony H. Johnson  19a. Informant's Name/Relationship (Type		19b. Mailin	g Address	(Street an	Lori :	Lee Har	t umber, City	or Town, Sta	te, Zip Code)	
nore, N	ages 1 and nf of Health t: If Item 27 7 or other tr		Lori L. Logan (mother 20a. Method of Disposition 1 M Burial 2 Cremation 3 Ren	20b. Pla	ace of Dispos metery, crem	sition (Name	e of her place)		Date	20c.	Location - City	MD 218	
Baltimore,	permit. Po Departme Important any injury		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Down	ing's	Name and	Address AV Me	of Facility	1/2004 Funeral Pocomo	Home	. P.A.	, Virgin	nia
	Physician physician and physic	dicai Examiner	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ance of):			such as card	liac or respirato	ory arrest,		Approxin Interval E Onset an	Between
.O. Box 68	Ine law requires that the death certificate be executed to has been signed by the attending physician and lage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23c. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ■ Unknown	If yes, outcome of pregnand 1 □Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	leath 3□E	Ectopic pred Other (spec					23d. Date of Month	delivery Day	Year
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tal Rec		e Completed	25. Was case referred to medical						DXY	utopsy erformed? es 2 \( \sigma\)	prior		s available cause of
ivision	tending Physieath. tor: After this the funeral dir	Certification: To B	1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 EF	-	280 M	Cther: c. Injury at Work? 1  Yes	4 Nursing	28d. Descri	desidence be how injuing the of Ut on (Street as	THE INVO	Pecify) at S  PLUED IN  Rural Route Nu  (P RO	COLLISIO
	within 24 hours after of All within 24 hours after completely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying Physici 22 Medicel Exeminer.	en: To the best of my knowle On the basis of examination and manner stated.	edge, death on and/or inve	occurred at estigation, in	the time, n my opin	date and pla ion, death oc	ce and due to t	the equee/s	) and manner	on state d	(s)
,	with Con	Σ	29b. Signature and title of certifier			OCI	icense n	umber				onth, Day, Year) 3 , 2004	
1	2		30. Name and address of person who comp  AWA RUB (  31. Date filled (Month, Day, Year)	, HO		111	Penr	Stree	et, Bal	timor	e, Mary	yland 21	201
	Sta Registr		AUG 3 0 200	32. Registrar's Signatur	K G	cole							

		Í	1 - State Registrar AMEND #8p		aryland / Dep 4,BW,Mcc <i>Ce</i>			na Wentar	Hygiene Reg. No	1001	28948
	Physici /Medio		1. Decedent's Name (First, Middle,  Jean Kutney	Last)		_		2. Date Mont Augu			3. Time of Death
	Examir		4a. Fecility Name (If not institution,	give street and number)		4b. City, Town, or				County of Death	
			Shaly Grove A	tdventist	Hospital	Kockv				Montgon	
	Funeral		5. Social Seculity Number 196–22–2557	S.Sex 7.Ag 1 M 2 X F	e (In yrš. last birthday, 76 Yrs.	Months Days	If Under 2 Hours	Min. 8. Date	of Birth20 h, Day, Year)	9. Birth	place (State or Foreign ntry)
	Director		Usual Residence of Decedent		70		L	Sept	<del>- 45</del> , 15	27   PA	
	yland		10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	a-f st	ctor	MD Montgo	mery	Gai	ithersburg	3				1 ☐ Yes 2 💢 No
	or 28	Olre	10e. Street and Number	"		10f. Zip Code			10g. Cit	izen of What Cou	ntry?
	ath w	ral	101 Odendhal Ave				2087			ted Stat	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be natified at once.	by Fune	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Armed Forces?  1 Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Orig an, Mexican, Specify:	in? (Specify Yes Puerto Rican, et	or No-	14. Race - Ameri Black, White Specify:	
Ö	2 hot	ted	15. Decedent's		16a. Dece	dent's Usual Occup	ation	-4	16b. K	ind of Business/Ir	
2	thin 7	nple	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	life.	o kind of work done of DO NOT use retired	during most	or working	ŀ		
7	ygien ygien her th	Cor	12			Homemaker				wn Home	
Maryland 21215-0036	Mental H Mental H Brked otl	To Be	17. Father's Name (First, Middle, La John Dewitt	ist)				's Name (First, M adore Ro			
	alth and 2 should alth and 27 is m		19a. Informant's Name/Relationship Edward Kutney/ S			ing Address (Street and Sutton Pl					o Code)
ore,	of He		20a. Method of Disposition 1 Burial 2 Termation 3	I □ Bomoval from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other plac	(e) A	Date 20		ocation - City or T	own, State
Ĕ	Pag ment ant: I		`4 □ Donation 5 □ Other (Spe		Metropoli			ugust 20 2004		_	Virginia
Baltimore,	Depart Depart Import any in		21. Signature of Funeral Service Li	Air .		2. Name and Address Deer Park	ss of Facility Drive	DeVol F , Gaithe	uneral rsburg	Home, 1, MD 208	0 East 77
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused nly one cause on each li	the death. Do not en ne.	ter the mode of dyin	g, such as c	ardiac or respirat	ory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ Methic	Ilin Resi	stant St	aph	Aureus	Sept	cemia	6 days
	/Medical Examiner		, southing in assum,	Due to (or as	a consequence of):	= 1	1		`		0 120020
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	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Acut	William.	7) 1					10.55
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			For State Registrar	State of	f Maryland		artment rtificate				lental Hy	giene	004	28919
			Decedent's Name (First, Middle	, Last)							2. Date of D	eath		3. Time of Death
	Physici /Medic		Albert Emil Kru	eger							Month	15C	2004	Olion
	Examin		4a. Facility Name (If not institution	give street and num	nber)		4b. City, 1	Town, or	Location of	of Death	) *	4c. 0	County of Death	111
			Mallard Bay Car					bri				D	orchest	er
	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	av. Year)	Con	place (State or Foreign ntry)
	Director		218-16-5969 Usual Residence of Decedent	<b>H</b>	82	115.					Jan. 3	0,192	22 Mary	land
	land ow		10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits
5	Many Ff sh	to	Maryland Dorche	ster	Rhode	sdale								1 ☐ Yes 2 🕅 No
2	h the	Director	10e. Street and Number				10f. Zip (	Code				10g. Citiz	en of What Cou	intry?
20	th wit		4941 Maiden For	est Road				2165	59				USA	
Sh	d within 72 hours after death with the Maryland piene. Ir than "naturel", or Items 23a or 28a-f show Ite Mozical Examiner must be notified at	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S	6. 13.	Was Decede	ent of Hi	spanic Ori	gin? (Spe	cify Yes or N Rican, etc.)	0- 1-	4. Race - Ameri Black, White,	
36	s afte , or It	by Fu	1 X Never Married 2 Marri 3 Widowed 4 Divorced	If Yes, Giv	е		1 ☐ Yes 2		Specify:				Specify:	White
Ş	hour turel	Di Di	15. Decedent	Year or Da	ates:	162 Dogg	dent's Usual	Occupa	tion					
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/lar	should be ind Mental s marked o umatic eve	ToE	Albert G. Krueg	er					Ida	Ros	e Diska	au		
an	2 sho and I Is me		19a. Informant's Name/Relationsh	nip (Type, Print)									Town, State, Zij	
≥ `	and Balth n 27		Lou Ann Truitt/	Niece					rest				Le, MD 2	
ore	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition  1 Burial 2 Cremation	3 ☐Removal from S	State ce	ace of Dispo metery, crer	natory or oth	her place	· 1		ate	20c. Loc	ation - City or T	own, State
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Baltimore, Maryland 21215-0036	permit. Pages 1 Department of I- Important: If ite any injury or ot		21. Si nature of Funeral Service L	icense	Kell	Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	Name and eller 06 Mai	Fune In St	s of Facilit eral treet	Home , Ea	, P. O st New	Box Marke	207 et, MD :	21631
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Y	/Medical Examiner		resulting in death)	Due to (	or as a consequ	ence of):	L							677.00
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	Due to (	or as a consequ	ence of):								
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Division of Vital Records, P.O	res tha igned be del	by P	Part II. Other significant conditio	ns contributing to de	ath but not resul	lting in the u	nderlying ca	use give	in in Part I.		23e. Did	tobacco use	e contribute to t	he cause of death?
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မိ	e lawr has be je 2 sh	ple	V	~							24a. Was	an	24b. Were auto	ppsy findings available mpletion of cause of
<u></u>	The ate ha	Completed									perfe	rmed? 2 Nö	death?	2KINO
/ita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?							of Death	(Check only	one)		
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n C	ing F	lon	27. Manner of Death  1. Anatural 5 Pending		h, Day Year)	28b. Time of Injury	M 28	c. Injury Work	at ? ′es 2 □ N		8d. Describe	now injury	occurred	
<u>is</u>	Attending r death. ector: After by the funer	Certification:	2 Accident investig 3 Suicide 6 Could n	ot be	of Injury - At hor	ne farm str			65 2 []		98f Location /	Street and	Number or Russ	al Route Number,
οį	l or A after Dire	ertii	4 ☐ Homicide determi	ned buildir	ng, etc. (Specify)	1	oot, lactory,	Onice			City or To	wn, State)	TVGTTD OF OT TIGE	a riodia ivamber,
	Hospital	al C	29a. Certifier	Physician: To the	best of my know	rledge, death	occurred at	t the time	e, date and	d place, a	and due to the	cause(s) a	nd manner as s	tated.
	To the Hospital or Attending Physwithin 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral di	edical	(Check only 2 Medical E	xaminer: On the ba and mann	isis of examinati	on and/or inv	vestigation, i	in my op	inion, deat	h occurre	ed at the time,	date and p	lace, and due to	the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	2			29c.	License	number			29d. Date	signed (Month,	Day, Year)
			Whatele	lan			1	176	638	58		Mys	st 26	2004
			30. Name and address of person v	vho completed cause					11	/	1	100	1/1 "	
-			Michael In	Fadd ev	-	302 0	E1/12	5	1/4	05/00	H VN	4 1	104	5
	Sta Registr		31. Date filed (Month, AUG 3	0 2004 <sup>32. Re</sup>	egistrar's Signati	J. A	Joels	1						

		1 - For Stata Registrar		laryland / Depa		Health and M	lental Hygien	е	
		Registrar  1. Decedent's Name (First, Middle, L.)	act)		uncate of	Dealit	Reg. N 2. Date of Death	0;	22950
Physic	ian	MA		ZTEC	na an an an an an an an an an an an an a	_	Month D	ay Year.	3. Time of Death
/Medi					EWETTER		Aug. 30		1526 M
Exami	ner	4a. Facility Name (If not institution, g		, , ,	4b. City, Town, o	or Location of Death	4	c. County of Death	
-		Peninsula Legion	al Medica	/ Center	Sali	If Under 24 Hrs.		Wicon	rico
Funeral		5. Social Security Number 6. 215-42-9180	Sex 7. Ag	ge (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Yea		place (State or Foreign intry)
Director		Usual Residence of Decedent		39			11-16-4	14	MD
land <b>ow</b>		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
Man, -f sh	ţo	MD. Wicom:	ico	Willard	S				1 Yes 2 No
the	rec	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Cou	intry?
3a o	0	7404 Canal St	treet		21874	1		U.S.A.	
death with the Maryland ms 23a or 28a-f show	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (Spe Jan, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	ican Indian,
after or training		1 ☐ Never Married 2 Married	Armed Forces	No	_		Rican, etc.)	Black, White	, etc.
0003 Nours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ Ne	Specify:		Specify: Wh	nite
wenter 1762 S−42-91 d 21215-003 filed within 72 hours Hygiene. Hygiene. there has netural, out, the Medical Exa	Completed	15. Decedent's l (Specify only highest g		16a. Deced	ient's Usual Occup	pation during most of workind)	16b.	Kind of Business/li	ndustry
127 E . E	ppl	Elementary/Secondary (0-12)	College (1-4or	5+) life. I	DO NOT use retire	d)	''g		
212 Se wind with the state of t	Con	12			Homemak	T		Own Ho	ome
SEUC 215- Iland 21 Iland 21 Iland Siled w Jenial Hygier Ired other th	Be (	17. Father's Name (First, Middle, Las	-			18. Mother's Name	(First, Middle, Maide	n Sumame)	
aryla should to market	၉	David Morri	İs			Cathe	erine Be	11	
ドだらをいてTTCA 215-42-9180 <b>Maryland 21215-0036</b> id 2 should be filed within 72 hours after death with and Mental Hygiene. It is marked other than "natural", or tams 23a. Triaumatic event, the Medical Examiner must be transmissed.		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	g Address (Street	and Number or Rura	al Route Number, City	or Town, State, Zi	p Code)
- 127 light - 1		Jens Wahlmann	Spouse		4 Canal		llards, M	id. 2187	7 <b>4</b> 1
MARY E.  Baltimore, oermit. Pages 1 at Department of Hea important: If than any injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	ce)	Date 20c. I	Location - City or T	own, State
MARY E.  Baltimori  permit. Pages: Department of Pimportant: If its any injury or of once.		`4 □Donation 5 □Other (Spec	ify)	Sunset	Mem Par	k 9-2-	-04 Be	rlin, M	íd.
alt alt alt alt apparti		21. Signature of Funeral Service Lice	ensed /	22	. Name and Addre	ess of Facility			
		March 116	W	U	llrich	Funeral	Home Ber	lin, Md	. 21811
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that cause v one cause on each I	d the death. Do not entine.	er the mode of dyir	ng, such as cardiac o	or respiratory arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	,	SEPSIS					Onset and Death
/Medical		resulting in death)	Due to (or as	a consequence of):					DAYS
Examiner		Opening the line and the con-	b	PNEUMO	NIA				9 Daves
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					7
cutec	Examiner	that initiated events	c.						
, 1760, the be executed by sician and purial-transit		resulting in death) Last	Due to (or as	a consequence of):					
2 2 2	ical		d.						
Box 68 Both certifica attending ph	Physiclan/Med	IF FEMALE:							
SOX th ce tendi	an/I	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		Ectopic pregnancy	v		23d. Date of deliv	*
S dea	sicl	in the past 12 months? 1 Yes 2 No	4□Pregnant a 9□ Unknown		Other (specify)	,		Month	Day Year
P.O. hat the ded by the deded is detached is	hy	9 Unknown							
cords, P w requires that s been signed to should be dest	by !	Part II. Other significant conditions			iderlying cause giv	ven in Part I.			he cause of death?
ould outd	ted	- UIABE	TES MEU	LITUS			1 ☐ Yes Ş	No 3□ Prol	babły 4 Dunknown
ecc law r as be 2 sh	ompleted		RTEUSIO	N			24a. Was an autopsy	24b. Were auto	opsy findings available impletion of cause of
The The page	ПО	l					performed?	death?	
Division of Vital Records, I or Attanding Physician: The law requires taffer cleath. Diractor: After this certificate has been signed in by the funeral director, page 2 should be	Be C	25. Was case referred to medical examiner?				26. Place of Death		2	
f V nysic nis ce direc	2	1 Yes 2	Hospital: 1 Inpati	ent 2 ER/Outpatien	t 3□ DOA Oth	ner: 4 Nursing Hon	me 5 Residence	6 ☐Other (Special	fy)
n o ng Pt tter tt neral		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time of Injury	28c. Injur Wor	y at 2	28d. Describe how inju	ry occurred	
andir andir oath.	atic	2 Accident investigation	on			Yes 2□No			
r Att	ertification:	3 Suicide 6 Could not determine	d 280. Place of In	jury - At home, farm, stre tc. (Specify)	et, factory, office	2	28f. Location (Street a City or Town, Stat	nd Number or Run	al Route Number,
Division of Vital Records, P.O. Box 68 To the Hospital or Attanding Physician: The law requires that the death certifica within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as it	O		1					,	
t hour trough	ledical	29a. Certifier Certifying P	hysician: To the best	of my knowledge, death of examination and/or inv	occurred at the tin	me, date and place, a	and due to the cause(s	s) and manner as s	tated.
the Prin 24 tha F	led	one)	and manner st	ated.					
vith To To	Σ	29b. Signature and title of certifier	Kul /	1 That	29c. Licens		29d. Da	ate signed (Month,	Day, Year)
		PYCONALD P.	MANTE	ms /	MDB65	176	8	30/04	G
C- (		30. Name and address of person who	·				_	//	
27 6		ROWALD	P TRA		> 560	RIVERS	IDE DR	SAKISE	SURTUR
Sta Registi		31. Date filed (Month, Day, Year)	2	rar's Signature					/

		_	For State		State	of Maryla		artment of H		and Mer		ene g. No. 🤈	001	20051
F.	Physici		1. Decedent's Name (First,  MARGARET (		E LAN	GLEY					Date of Death Month	Day	2004	3: Time of Death  1:50 PM
	/Medic Examin	_	4a. Facility Name (If not ins.	ritution, give s	treet and no			4b. City, Town, o			cp och we	4c. Co	ounty of Death	1.50 111
1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 /	Funeral Director		5. Social Security Number 579–05–8276		м <b>ж</b> F	7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Dey, OV 27 1		9. Birthp Cour New	
	Maryland -f show lied st		Usual Residence of Decederation 10a. State 10b. C			10c.	City, Town or Lo							10d. Inside City Limits 1 ▼Yes 2 □ No
	with the	i Director	10e. Street and Number	e Stre	et	1		10f. Zip Code 206	501	- ,	10	g. Citize	n of What Cou	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar risk to milling at ance.	by Funerai	11. Marital Status  1 Never Married 2  3 X Widowed 4 Div	Marned	Armed F	2 XNo	U.S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 X No		gin? (Specify i, Puerto Ric	y Yes or No- an, etc.)		Race - Americ Bleck, White, pecify: Whi	etc.
21215-0036	within 72 hou ene. then "nature he Medical E	Completed	15. De (Specify only Elementary/Secondary (0 11		complete a	) (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire utician	during most	t of working			of Business/In	
Maryland 2	should be filed nd Mental Hygi merked other umatic event, I	To Be C	17. Father's Name (First, N William Pr						Mari	on Pr				
	and 2 sho balth and n 27 is mu		Wayne M. De					ng Address (Street 7 Hill St						_
altimore,	Pages 1 and of Heiling It is the mint: If item iny or other		20a. Method of Disposition  1 Description  2 Crem  4 Donation 5 Of		lemoval fron	n State	cemetery, cre	osition (Name of matory or other pla		Date 9-7-04			tion - City or T	own, State Maryland
Baltin	permit. P Departme Importan any injury once.		21. Signatur of Full ral S		811	M0017	3 2	2. Name and Addre	ess of Facility	y Ebery	wein Fu	nera	al Serv	ices
No. of Lot	Physician /Medical Examiner		23a. Part : Enter the disection of heart failure in mediate Cause (Final disease or condition resulting in death)	ise, or compli b. List only or	ne cause on	caused the dieach line.	es &1	0 10	ng, such as	cardiac or re	espiratory arre	est,		Approximate Interval Between Onset and Death
8760,	certificate be executed rding physician and use as the burial-transit	Ilcai Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	o	o (or as a cons								
P.O. Box 6	death certific e attending p od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnin the past 12 months 1 Yes 2 50 9 Unknown	ant	1 Live	utcome of pre- birth 2 F gnant at time on nown	etal death 3	□Ectopic pregnanc □ Other (specify) _	Э			23	d. Date of deliv Month	ery Day Year
	es be	by	Part II. Other significant c	onditions cor	ntributing to	death but not	resulting in the	underlying cause gi	ven in Part I.					the cause of death?
Vital Records,	The law ate has b page 2 s	Completed									24a. Was ar autopsy perform 1 ☐ Yes 2	y	24b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available ompletion of cause of
of	ding Physician: Th n. After this certificate funeral director, pag	n: To Be	25. Was case referred to rexaminer?  1 Yes 2 No  27. Manner of Death	F		Inpatient 2 e of Injury onth, Day Year	2 ER/Outpatie	III 30 DOX	her: 4 Nu	ırsıng Home	5 side	nce 6	□Other (Speci	fy)
Division	or Attandation death	Certification:	2 ☐ Accident	Pending investigation Could not be determined	28e. Pla		at home, farm, s		Yes 2 🗀		Location (Str City or Town	reet and i	Number or Rur	al Route Number,
	Hospital 24 hours a Funeral l letely filled	edical C	29a. Certifier (Check only 2 one)	ertifying Phy edical Exami	ner: On the	he best of my basis of exam anner stated.	knowledge, dea nination and/or i	th occurred at the to nvestigation, in my	ime, date an opinion, dea	nd place, and ath occurred	d due to the ca at the time, da	iuse(s) a ate and p	nd manner as s lace, and due t	stated. to the cause(s)
•	To the within 2 To the complet	Me	29b. Signature and title of	certifier	- 14	Mes	C	29c. Licen	se number	52	29	9d. Date	signed (Month,	Day, Year)
-	BB		30. Name and address of	person who co	ompleted ca	use of death (	Item 23a) (Type	Plate	N	al	201	66	16	
	St	ate	31. Date filed (Month, Day	O°2 201	04 32	Registrar's Si	gnature	25416						

		1. Decedent's Name (First, Middle	le, Last)								2. Date of Month	Da	av	Year	3. Time o	
Physicia /Medica		Camryn Rylei	gh La	in							Septe	mber	04	, 200	4 1957	P
Examine	er	4a. Facility Name (If not institution					, ,		Location	of Death				nty of Deat		
		Frederick Memor						deri		04300			Free	deric		
Funeral Director		5. Social Security Number 213-57-0912	6. Sex	1 2 1 /	7. Age (In yrs.	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of (Month,  Decemb	Day, Year,	<sup>2</sup> , 1	Co	thplace (State buntry) Mary	
M. II	-	Usual Residence of Decedent  10a. State 10b. County	,		10c. Cit	ty, Town or Lo	cation								10d. Inside C	ity I
r 28e-f show a notified at	ē N	Maryland Fre	ederi	ck		Fred	erick	1							1 <b>⊠</b> Yes	•
28e notif	O L	10e. Street and Number			1		10f. Zip					10a. Ci	itizen o	of What Co	ountry?	_
0 24	ੂ	910 Walnut Str	eet				2	1703	}			_	5.A.		,	
. Je	by Fur	11. Marital Status  1 KNever Married 2 Mar 3 Widowed 4 Divorced	ried	Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	•		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or Rican, etc.)	No-		lack, Whit	encan Indian, e, etc. hite	
jiene. r than "naturel", Ine Medical Ex	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)			4or 5+)	16a. Dece (Give life.	dent's Usua kind of won DO NOT us	al Occupa rk done d se retired)	ation Juring mos )	t of work	ing	16b. K	Kind of	Business/	Industry	
ntal H	To Be C	17. Father's Name (First, Middle, Robert La.		3234-0						er's Name	ewis	dle, Maider	n Sumi	ame)		
들었 후		19a. Informant's Name/Relations Susan Lewis - I				19b. Mailir <b>910</b>	ng Address <b>Walnu</b>	(Street a	nd Numbe	er or Rura Fre	al Route Num	nber, City o	or Tow	m, State, 2 Land	Zip Code) 21703	
or othar	1	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation		noval from Si	tate	Place of Dispo cemetery, crer	natory or ot	ther place	· 1		Date				Town, State	
tmer tent: jury	-	`4 □Donation 5 □Other (S	4		Fre	ederick			_		/2004			_	Maryla	m
Department of Importent: If i any injury or one once.		21. Signature of Funeral Service	icensee		11	22	2. Name and	d Addres	s of Facilit	<sup>y</sup> Staı	uffer	Funer	ra1	Home		
0 = 8 0		Sharon U	Mil	le G	allen	e	1621	0pos	sumt	own ]	Pike,	Frede	erio	ck, <sub>2</sub> M	aryland	l
- 1		23a. Part1. Enter the disease, or shock, or heart failure. List	r complicat t only one o	tions that car cause on ear	used the deat ch line.	th. Do not ent	er the mode	e of dying	g, such as	cardiac c	or respiratory	arrest,			Approximation Interval Bet	e wee
ysician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	r complicat t only one o	cause on ear	cn line.	th. Do not ent	er the mode	e of dying	, such as	cardiac d	or respiratory	arrest,			Approxima	e wee
Medical		Immediate Cause (Final	r complicat t only one o	Drown	cn line.		er the mode	e of dying	g, such as	cardiac d	or respiratory	arrest,			Approximation Interval Bet	e wee
		snock, or near failure. List Immediate Cause (Final disease or condition resulting in death)	r complicat t only one o	Drown	ning		er the mode	e of dying	g, such as	cardiac d	or respiratory	arrest,			Approximation Interval Bet	e wee
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		1. Decedent's Name (Firs	t, Middle, Last)				_		Death	2. Date of De	Day		ear	3. Time of Death
Physici /Medio		Bruce		James			Musc	olin	.0	8/20/2	004 <sup>ay</sup>	Υ.	ear	8:25 P
Examir		4a. Fecility Name (If not in	stitution, give s	street and number	r)		4b. City,	Town, or	Location of Death	1	4c.	County of	Deeth	
		Montgomer					01r	-				ontgo		
Funeral Director		5. Sociel Security Number 290 34 41. Usual Residence of Dece	34 X	M 2□F	ge (In yrs. Ia 64	Yrs.	If Under Months		Hours Min.	8. Date of Bir (Month, De July 2	7, Year)	940	Birthpl Coun <b>Oh</b> :	ace (State or Fore try) LO
Mo T			County		10c. City,	Town or Loc	cation						10	d. Inside City Lim
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28e-f show appring to other traumatic event, the Medical Examiner must be notified at ance.	Funeral Director	Maryland 10e. Street and Number	Montgo	mery	Si	ilver	Sprin				10g. Citi	zen of Wha	at Coun	1 ☐ Yes 2 🔼 I
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Hygic htt.		17. Father's Name (First,	Middle, Last)	4		ETECL	LICA	LENE	18. Mother's Nan	ne (First, Middle	, Maiden		111	
ked o	To Be	James Musc	olino						Joseph	ine Cr	isaf	ulli		
h and Mental Hygiene. 7 ie marked other than " Iraumatic event, Ira Mes		19a. Informant's Name/R	elationship (Ty	rpe, Print)		19b. Mailin	g Address	(Street a	nd Number or Ru	ral Route Numb	er, City o	r Town, Sta	ate, Zip	Code)
n 27 i		Donald Cris		/_Cousin		14613	Pebl	lest	one Driv					20905
S E E		20a. Method of Dispositio	mation 3 🗆 R	Removal from Stat	9	ace of Dispos metery, cren 11awn				Date 0/2004		cation - Cit		
Departm Importal eny inju		21. Signature of Funeral			<u> </u>	22	. Name ar	nd Addres	n of Facility	.800 New				
ysician and Medical series and paragraph and	cal Examiner	disease or condition resulting in death)  Sequentially list condition rany, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	is.	Due to for a	is a consequence	onico ul).	Luca	2						
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fler this certificate has been signed by the attending phys ineral director, page 2 should be detached for use as the	To Be Completed	in the past 12 month 1   Yes 2   No 9   Unknown  Part II. Other significant    Compared to the part of	medical Pending investigation Could not be determined Certifying Phys Medical Examin	Hospital: Inpa  28a. Date of In (Month, D  28e. Place of In building,  sician: To the besiner: On the basis	tient 2 E jury yay Year) njury - At horelc. (Specify, st of my know of examinati	EP/Outpatien 28b. Time of Injury	M aget, factory	Other Page Injury Norwa	at ?  (es 2 No	24a. Was auto perfect of the Check only to ome 5 Resident 28d. Describe 28f. Location (City or To	an ppy promed? 2 2 No pne) dence (how injury Street and state, and date and date and	prio dea 1	or Rural or as sta	Aoute Number, ated. the cause(s)
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			Registrer  1. Decedent's Name (First, Middle, Last)		007	imouto or		2. Date of Death	-	111	3. Time of	Death
	Physicia	an						Septemb	er 6.	2004	757	ам
	/Medic		Seth Joshua Morgan  4a. Facility Name (If not institution, give st	reet and number)		4b. City. Town. o	r Location of Death			ty of Death		
	Examin	er	45887 Bob's Cour				gton Parl			t. Mar	y's	
	Francis		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year		8 Date of Birth		9. Birthol	ace (State o	r Foreign
	Funeral Director			M 2□F	Yrs.	Months Days 2 18	Hours Min.	(Month, Day, June 18,20			ace (State o	
			Usual Residence of Decedent			2 10	1	June 10,20	704	Maryla	and	
	hours after death with the Maryland tural; or Items 23e or 28e-f show al Exactinat must be notified at		10a. State 10b. County	10c. City, T	own or Loc	ation		_		10	d. Inside Ci	ty Limits
	Mar Har	to	Maryland St. Mary's	Lexina	gton Pa	ırk					1 🗌 Yes	2 🙀 No
	28e	Director	10e. Street and Number		, , , , , ,	10f. Zip Code		10	g. Citizen of	What Coun	ry?	
	3e or		45887 Bob's Court			20653			USA			
	Jeath Ins 2	Funeral		2. Was Decedent Ever in U.S.	13. W		Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14. Ra	ce - America		
	fter of	μ̈́	1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2♥♥No				o Rican, etc.)	BI	ack, White, e	tc.	
ğ	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2∏ No	Specify:		Spec	<i>ify</i> : White	2	
Maryland 21215-0036	2 hou	per	15. Decedent's Educa	ation 1	6a. Deced	ent's Usual Occup	pation	1	6b. Kind of	Business/Ind	ustry	
5	filed within 72 Hygiene. ther then "natem", and the malls	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give I life. D	rind of work done O NOT use retire	during most of word)	king				
7	iene iene	E	0	College (1-4or 5+)	None				None			
0	filed Hygi other ent, I		17. Father's Name (First, Middle, Last)		,,,,,,,		18. Mother's Nan	ne (First, Middle, M	laiden Suma	ime)		
a	ould be Mental I arked o	To Be	Joshua Ralph Morgan				Jennifer	Elaine Maye	s			
≥	and Men is marke	Ě	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailin	Address (Street	1	ral Route Number,		n. State. Zip	Code)	
<u>8</u>	tre tre		Jennifer Elaine Mayes/					on Park, Ma			ŕ	
Ψ	permit. Pages 1 an Department of Heah Importent: if Item 2 any injury or other once.		20a. Method of Disposition	20h Place	e of Dispos	ition (Name of			-	- City or To	vn, State	
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_	GD 5 8 0			ens			, Maryland					
Ш.			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. It is cause on each line.	Do not ente	r the mode of dyli	ng, such as cardiac	or respiratory arre	st,		Approximate Interval Bet Onset and [	ween
	Physician		Immediate Cause (Final disease or condition	Sudden Unexpla	ained	Death i	n Infancy	e			Onset and t	Jean
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ŏ	ndin use	N/	IF FEMALE: 23 23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy	, a = 0	e			23d. D	ate of deliver	у	
P.O. Box	death a atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)	y 		N	lonth	Day 1	rear
o.	the cry the	Jysi	9 Unknown	9□ Unknown								
	The law requires that the death certifica site has been signed by the attending ph age 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions cont	tributing to death but not resultin	ng in the un	derlying cause gru	ven in Part I.	23e. Did toba	acco use cor	ntribute to the	e cause of d	eath?
g	uires sigr ld be	d b						1 ☐ Yes	2 <b>(N</b> )	3 Proba	ibly 4 🗆	Jnknown
Ö	w require been si	Completed						24a. Was an	245	. Were autop	ey findings	available
ĕ	has has	ш						autopsy			pletion of ca	
<u>=</u>	ysicien: The lis certificate hadirector, page								□ No	1 Yes	2□ No	
ij	icien Sertifi ector	Be	25. Was case referred to medical examiner?	ospital:		O#		th (Check only one				
1	Physic this al dir	은	132 195 2 100	1 Inpatient 2 ER				ome 5 Resider				scene
_	Ing F	on	27. Manner of Death 1 □Natural 5 □ Pending		b. Time of	28c. Injui Wor	rk?	subject a	asleep	with	mom o	n
Division of Vital Records,	Attending Physicien: or death. ector: After this certificaby the funeral director.	cati	2 Accident investigation	found fe	ound_a	4	Yes 2 No	sofa				
$\geq$	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)		et, factory, office		28f. Location (Stree City or Town,	State) 45	887 B	ob s C	ter,
	To the Hospitel or within 24 hours afte To the Funerel Dir. completely filled in I		<u> </u>	found at home	e			Lexington	n Park	, Mary	Land	
	fosp t hou fune	edical	29a. Certifier 1 Certifying Physi (Check only 2 Medicel Examin	ician: To the best of my knowle er: On the basis of examination	dge, death and/or inv	occurred at the till estigation, in my o	me, date and place	, and due to the car rred at the time, da	use(s) and n	nanner as sta	ited. the cause(s	)
	the hin 24	edi	one)	and manner stated.					· · · · · · · · · · · · · · · · · · ·			
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. Licens				ed (Month, E per7 , : :		
				reenseigh.				3	-premi			
			30. Name and address of person who cor	mpleted cause of death (Item 23	Ba) (Type, 8	Print)		T 20-11-1	ma===	Max.1	and 21	1201
			Tasha Z Green	iberz M.D.			enn Stree	et, Balti	nore,	татут	au 2.	LZUI
	Sta		31. Date filed (Month, Day, Year)	3 Registrar's Signature	L	AS)						
	Regist	ar	SEP 0 8 2004	Brans De								

o. Physici	ian	1. Decedent's Name (First, Middle, Last			2. Date of Deat Month	Day	Year	3. Time of Death
/Medi	cal	4a. Facility Name (If not institution, give		4b. City, Town, or Location of De-	AUG	4c. County	2004	0907
Examir	ner	University of Maryland		Baltimore	atti	NIA	or Death	
uneral irector		016-17-17-1	X 7. Age (In yrs. last birthda	Months Days Hours Mi		Year) 1925	9. Birthplac	ce (State or Fore
Wor		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location			10d	I. Inside City Limi
itam 27 is marked other than "natural", or itams 23a or 28a-f show othar traumatic evant, the Medical Evantiner must be notified at	Funeral Director	MD Dorch  10e. Street and Number	ester Can	nbridge				1 MYes 2□N
ather	l Dir	1014 Camel	in Ainale	21613		og. Citizen of V	vnat Country	<i>y</i> ?
er en	nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No-		e - American k, White, etc	
	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify		
	Completed	15. Decedent's Edu (Specify only highest grad	e completed) (Gi	cedent's Usual Occupation ve kind of work done during most of w	orking	16b. Kind of Bu		
	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	· .	Food P	C 2 / - C	Shara
	O O	17. Father's Name (First, Middle, Last)	111700	cessing Line W	ame (First, Middle, N	faiden Sumam	(a)	31NG
	ToB		dward Milbo		a Etta			_
		19a. Informant's Name/Relationship (T)	rpe, Print) 19b. Ma	tiling Address (Street and Number or I				ode)
		20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place)	le CaMb	ridge 10c. Location	City or Town	1, State
		1  Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State		26/04 (	ambr	idee	MD.
once.		21. Signature of Funeral Service Licens	00 7/2	Cemetery 8/22. Name and Addr s of Facility Henry Funeral	Home, P. A.		0)	
٠		23a, Part I. Enter the disease, or compl	ications that caused the seath. Do not e	510 Washington 3	t. Cambri	dge, M	D. 21	613 pproximate
d for use as the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Degenerative Ac  Due to (or as a consequence of):  Degenerative according to the consequence of the consequence					
	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	B □Ectopic pregnancy D □ Other (specify)		23d. Date Mor	e of delivery oth Da	ay Year
sied ed binous	d by Pl	Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.				cause of death? ly 4 □Unknow
	Complete				24a. Was an autopsy perform	ed? d	Vere autopsy rior to compl eath? Yes 2	findings availabletion of cause of
	) Be	25. Was case referred to medical examiner?	lospital:		eath (Check only one			
	n: To	27. Manner of Death	1 ☑Inpatient 2 ☐ ER/Outpati	of 28c. Injury at	Home 5 Resider			
	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Stre City or Town,	eet and Numbe State)	er or Rural R	oute Number,
	Medical Ce	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the car curred at the time, dat	use(s) and mar te and place, a	nner as state	ed. e cause(s)
(iaia)	Me	29b. Signature and title of certifier	M.—	29c. License number		d. Date signed		y, Year)
completely filled in by the funeral director,		Josi (Jemy) or		AU 4176435 GREEN	13632	0/20	2004	

			1 - For State Registrar	State of Marylar	nd / Depa		of H	ealth an		ygiene Reg. No.		28956
	Physic /Medi		1. Decedent's Name (First, Middle, Last Effie Mae	) Elizabeth	Moore	2			2. Date of D Month Augus 1	Day	2004 Yeer	3. Time of Death 4:15 P M
	Examir		4a. Facility Name (If not institution, give 3875 Marvin Driv	e		India	an He		Death	4c. C	ounty of Dea harles	th
	Funeral Director		5. Social Security Number 6. Security Number 10 6. Security Number	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	Hours I	Min. 8. Date of B (Month, D March	18, 1	9. Bin Co 919 Ma	thplace <i>(State or Foreign</i> ountry) ryland
4.0	be filed within 72 hours after death with the Maryland nat Hygiene. od other then "naturel", or items 23e or 28e-f show event, the Medical Examinat must be notified at	Funeral Director	10a. State 10b. County Maryland Charles 10e. Street and Number 3875 Marvin Drive 11. Marital Status 1 Never Married 2 Married	In  12. Was Decedent Ever in U	dian H	ead 10f. Zip (	2064	-	? (Specify Yes or N uerto Rican, etc.)		en of What Co USA 4. Race - Ame Black, Whit	encan Indian,
21215-0036	d within 72 hours at giene. r then "naturel", or the Medical Exem	Completed by I	3 XWidowed 4 Divorced  15. Decedent's Edu (Specify only highest grad  Elementary/Secondary (0-12) 6	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:  cation e completed)  College (1-4or 5+)	16a. Dece	dent's Usual kind of work DO NOT use	Occupat done du retired)	iring most of	working		Specify: Word of Business	,
Maryland 2	d a d	To Be C	17. Father's Name (First, Middle, Last) William Southerlan					18. Mother's Ma	Name (First, Middl ggie Eliz	abeth	<sup>lumame)</sup> Murph	У
Baltimore, Mar	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any njury or other traumatic ODE®		19a. Informant's Name/Relationship (Ty Woodrow B. Moore – 20a. Method of Disposition 1 \( \mathbb{X}\) Burial 2 \( \mathbb{Cremation} \) 3 \( \mathbb{P}\) 4 \( \mathbb{Donation} \) 5 \( \mathbb{Other} \) (Specify) 21. Signature of Funeral Service Licens	Son  temoval from State  Tri	3875   Place of Dispo cemetery, crem nity Mo	Marvir sition (Name natory or oth emoria . Name and Intt F	n Dr e of er place al Go Address uner	ive, I dns 9-	ne	d, MD 20c. Loca Waldo	20640 ation - City or rf, MD	
	Pnysician /Medical Examiner	ılner	23a. Part 1. Enter the disease, or comples shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ne cause on each line.	Dofla Juence (1): Ma	er the mode	of dying,	such as car	1dorf, ME diac or respiratory	arrest,		Approximate Interval Between Onset and Death Cary S.
O. Box 68760,	it the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Medical Examiner	IF FFMALE:	Due to (or as a consequence of pregnance)  3c. If yes, outcome of pregnance of Diction 2 Feta 4 Pregnant at time of deputy of the pregnant at time of deputy of the pregnance of	ancy	Ectopic pre				23	d. Date of deli Month	ivery Day Year
ecords, P.(	v requires the been signed should be de	by	Part II. Other significant conditions con  Coronay asse  Dianelus			nderlying cau	use giver	in Part I.	_ 1_	Yes 2 🕏	No 3□Pro	the cause of death?
Vital Re	The ate ha	se Completed	25. Was case referred to medical					26. Place of	24a. Was auto perf 1 ☐ Yes	ormed? 2 No	prior to c death?	topsy findings available completion of cause of
ō	Attending Physician: r death. sctor: After this certific by the funeral director.	ation: To B	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1  Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatien: 28b. Time of Injury		Other c. Injury a Work?	4 🗌 Nursin	g Home 5 X Fes 28d. Describe	idence 6[	☐Other (Spec	ify)
DIVISION	교육	i Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	y)				City or To	wn, State)		ral Route Number,
•	To the Hospitel within 24 hours a To the Funerel completely filled	Medical	29a. Certifying Phys (Check only) 2 ☐ Medical Examin  29b. Signature and title of certifier	itician: To the best of my knoter: On the basis of examina and manner stated.	tion and/or inv	estigation, in	n my opir License r	nion, death o	ccurred at the time,	date and pl	ace, and due	to the cause(s)
2	88		0 .01 / 0	tchford, 1	n 23a) (Type, F	Print) 404	C	harle	s St L	a Pla	ik h	.064 10 20646
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 2 20	32. Registrar's Signa	iture	25060	į.					

				State of Maryl			t of Health and e <i>of Death</i>	•	'giene Reg. No:() () ()	1 0	275 275 2000 mmg
	Physic		Decedent's Name (First, Middle, Last     LUCY MEYE					2. Dete of De Month August	eth Day Y	ear	Time of Death
	/Medi Exami		4a Fecility Name (If not institution, give				4b. City, Town, o	r Location of Deet			7.23 FII
			Charles County Nu	rsing & Reha	b. Cent	er	La Pl	ata	Cha	rles	
	Funeral Director		054-07-9797	х ]м 2 <b>X</b> ]F 7. Age (In )	vrs. lest birthde Yrs.	/) If Under Months	1 Year If Under 24 Hi Deys Hours Mi			Birthplace Country) EW YOY	(State or Foreign ↑K
	and and		Usual Residence of Decedent  10a. Stete 10b. County	10c.	City, Town or I	_ocetion				10d. ir	nside City Limits
	ith the Marylar or 28e-f show	to	Maryland Charles		Waldo	orf					□Yes 2 No
	ith the M or 28e-f	lrec	10e. Street end Number		Mara	10f. Zip	Code		10g. Citizen of Wha	at Country?	
	th wil	al D	2526 Ryce Drive				20601		USA		
20	within 72 hours after death with the Maryland ene. ene. than "natural", or frems 23e or 28e-f show ha Medical Examiner must be notified at	y Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	U,S. 13	Was Decede If Yes, speci 1 ☐ Yes 2	ent of Hispenic Origin? (fy Cuban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Race - Black, Specify:	American In-	
8	tural'	Q Da	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Detes:	16a Dec	edent's Usual	Occupation			Whi	
Baltimore, Maryland 21215-0020	77 12 1	Completed by	(Specify only highest grad	College (1-4or 5+)	(Giv life.	e kind of work DO NOT use Stress	k done during most of w e retired)	orking	16b. Kind of Busin		
bu	e filed wi	Be C	17. Father's Neme (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	, Maiden Surname)		
yla	d 2 should be filed th and Mental Hyg 7 is marked othe traumatic event,	To	Salvatore Ceparano				L	ucia Rega	a		
Mar	2 sho and is m		19a. Informant's Name/Relationship (T)	pe, Print)		_	(Street and Number or F				9)
e,	ges 1 and it of Health If item 27 or other tr		Arthur Meyer 20a. Method of Disposition	201	Place of Disc	osition (Nam.	Drive, Wal	dorf, Man	ryland 20 20c. Location - Cit		itata
Jou	iges it of		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cre t. Char	ematory or oth	ner place)	9-3-04	Farmingd		
altir	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to page.		21. Signature of Funeral Service Licens				Address of Facility	3 0 01	Tariiriigu	uie, n	
ä	Deport Impo		Mark M R	shana	Hu		neral Home ox 156, Wal	dove MD	20004		
delig	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the de le cause on each line.						Appr Inten Onse	oximate val Between et and Death
	/Medical Examiner	-	Immediate Cause (Final disease or condition resulting in deeth)	Due to	O (or as a conse	equence of):	1/4				ch
Ī	ficate be executed physician and st the burial-transit	Examiner		). ————————————————————————————————————	/					1	
ó	ificate be execut g physician and as the burial-trar		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a conse	equence on:					
68760,	ate be hysici the bu	edical	Cause (Disease or injury that initiated events resulting in death) Last	Due to	(or as a conse	quence of):		1.00			
	entific ding p	-									
Box	death cert e attendin ed for use	lan								1	
0	the de y the	by Physician/N	Part II. Other significant conditions con	tributing to death but not r	resulting in the I	underlying ca	use given in Part I.		obacco use contril		
0	s that ned b	Y P	-					10,	Yes 2□No 3[	☐ Probably	4 Unknown
of Vital Records,	sw requires that the death certific s been signed by the attending p 2 should be detached for use as	Completed b							an autopsy 2 rmed?	available	on of cause
H.	The law ate has b page 2 s	E O						101	65 212 No	1 ☐ Yes	2□ No
/ita	clan: ertifica ector,	Be	25. Was case referred to medical examiner?					ath (Check only o	ne)		
of	Physician: this certific ral director,	၉	1 ☐ Yes 2 ☐ No F 27. Manner of Ceath	The same of the sa	☐ ER/Outpatie				dence 6 Other (	Specify)	
UO	dlng F h. After funer	fon	1 Naturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	M 280	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe r	now injury occurred		
Division	or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - Al building, etc. (Spe	home, farm, st			28f. Location (S City or Tow	Street and Number o m, Stete)	r Rurel Rout	e Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier (Check only one)  Certifying Phys	ician: To the best of my ker: On the besis of exami and manner steted.	nowledge, deat nation end/or in	h occurred et	the time, date and plece may opinion, death occi	e, end due to the curred at the time, o	cause(s) and manne date and place, and	r as stated. due to the ca	ause(s)
D	To t To t	M	29b. Signature and title of certifie	0		29c.	0 2 ) 3 4 g	5	29d. Date signed (M	onth, Day, Y	'ear)
	BB5		30. Name and address of person who co	ine (to	#100	Print) Ja	day, M	21 2	0602		
P.	Sta Registr	. 3	31. Date filed (Month, Day, Year) SEP 0 3	32. Registrar Sig	nature	do	10				

	end			1- For TCHD, 8/23/		Ce	rtificate of	Death	1		04 2	28958
_		Physici /Medio		Decedent's Name (First, Middle, L Samuel Thomas	,	Sr.			2. Date of Dea Month	Day	Year	3. Time of Death 8:27 A M
		Examir		4a. Facility Name (If not institution, g UNIVEYSIYY GREET		, /	3b. City, Town, of Ba Him	or Location of Death		4c. Count Balt	y of Death imore	City
		Funeral Director		218-24-4551	Sex 7. Ag XXM 2□ F 7.	ge (In yrs. last birthday 2 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 11-16-	1931	9. Birthplan Country Tilg	ce (State or Foreign k) NMMan, MI
		the Maryland 28a-f show natified at	tor	Usual Residence of Decedent  10a. State 10b. County  MD Wicomi	CO	10c. City, Town or L Parsonsh					100	1. Inside City Limits  1. Yes 2 No
		th with the 23a or 28a	Funeral Director	10e. Street and Number 7959 Jones Has	tings Rd	•	10f. Zip Code 21849			10g. Citizen of USA	What Country	y?
	5-0036	s I and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. It has 12 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examination to interpretable in the contract of the contract of the medical Examination of the contract of the medical Examination of the contract of the medical Examination of the contract of	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 X If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		ce - American ick, White, etc fy: Whit	c.
ci	215-0	thin 72 ho e. an "natur Medical	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or	(Give	edent's Usual Occup s kind of work done DO NOT use retire	during most of work	ring	16b. Kind of E	Business/Indu	stry
Samue	2	should be filed withir or Mental Hygiene. marked other than matic event, It's M	Be	8 years 17. Father's Name (First, Middle, Las James Lindale		Wate	erman	18. Mother's Nam				
~	Maryland	and 2 should be ealth and Mental n 27 is marked o ier traumatic eve	To	19a. Informant's Name/Relationship C. Michelle Ma	(Type, Print)	19b. Mail daughter)	ng Address (Street	and Number or Rur	al Route Numbe	r, City or Town	, State, Zip C	sburg,MI
Nurphy	Baltimore,	Page: nent o ant: If ury or		20a. Method of Disposition  1 □ Squrial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec	ify)	Tilghma	matory or other pla	ial 8-20	Date 0 - 2004	20c. Location Tilgh:		
7	B	Huysician /Medical Examiner		23a. Part 1. Enter the disease, or corshook, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)	y one cause on each li	A consequence of):	en o no Po in	1/A	or re in try air		MD 2	
	98760,	be executed cian and burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Class (Tests of The y that initiated events resulting in death) Last	Due to (or as	a consequence of):	heomL	aliseus	9		5	yrs
	P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	☐Ectopic pregnance	,			ite of delivery onth Da	ay Year
	rds, P	quires that n signed b uld be deta	by	Part II. Dther significant conditions Corenary of theres								cause of death?
	Division of Vital Records,	The law requir sate has been si page 2 should	Completed	Respiratory Juille	re kuhilate	er clepende	en/		24a. Was a autops perform	med?	prior to compl death?	y findings available letion of cause of
	/ita	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	Lucian I			26. Place of Deatl				
	of	Physical direction	2	1 Yes 2 No		ent 2 ER/Outpatie		4   Nulsing Ho				
	sion	Attending I death. ctor: After y the funer	Certification:	27. Manyer of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	be	y Year) Injury	M 1□	Yes 2□No	28d. Describe ho			
	Div	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined	building, et	ury - At home, farm, st c. (Specify)			28f. Location (Si City or Towi	n, State)		
		the Hosp in 24 ho the Fune ipletely fi	ledical	29a. Certifier 1 <b>V</b> Certifying P (Check only 2 Medical Exa	thysician: To the best iminer: On the basis of and manner sta	examination and/or in	h occurred at the tir vestigation, in my o	ne, date and place, pinion, death occurr	and due to the cared at the time, d	ause(s) and ma ate and place,	anner as state and due to the	ed. e cause(s)
		Mith To COT	Σ	29b. Signature and title of certifier			29c. Licens		2	9d. Date signe		y, Year)
				30. Name and address or person who	completed cause of d	leath (Item 23a) (Type,  1   Ity he spite ar's Signature		10494		8/17		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician : 40 PM Alma LaVerne McKenna 04 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) **Examiner** Prince George's Prince George's Hospital Cheverly | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Mi 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Yrs. Washington, DC 577-36-8542 75 **Director** Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f ehow the Medical Exeminer must be notified at 1 X Yes 2 No Maryland Prince George's Cheverly Direct 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20785 U.S.A. 5819 Dewey Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. il Hygiene. other than "natural", or Itams Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Mamed 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 International Harvester Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic evant 900.8. Be George Edward White Alma Margaret Stokes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5819 Dewey Street, Cheverly, Maryland 20785 Alma Jeanne Scott - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Sept. 1, 2004 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 Jasch audette 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Due to (or as a consequence of): disease or condition resulting in death) Days /Medical Examiner pepsis Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in task of cause) Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 18 No Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 X No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this After the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D0061106 08.28.04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7202 Quisinberry Way, Bowie, Maryland 20707 Jyoti Jagtap, M.D. 31. Date filed (Month, Day, Year) 82. Registrar's Signature State AUG 3 0 2004 Registrar

			1 _ For State	State of	f Marylai	•	artment of rtificate of		Mental Hygier	0001	
			1. Decedent's Name (First, Middle, I	.ast)		001	incate of	Death	Reg.	No.	3: Time of Death
	Physici		KATHERINE		11/	MAC	NIEV			- 2004	1144 PM
	/Medio		4a. Fecility Name (If not institution, g			11/7/2		or Location of Dea	ith	4c. County of Beeth	INTIP
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	arylar show	-	10a. State 10b. County  Marvland Cari	-011	10c. C	ity, Town or Lo	estminst	0.10			lod. Inside City Limits
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	be filed within 72 hours after death with the Maryland ntal Hygiene. do other than "natural", or terma 23a or 28a-f ehow event, tra Medical Exam er must be multiad at	al Directo	10e. Street and Number 205 Saint Marks	Way			10f. Zip Code 2115	7	10g.	Citizen of What Coul	ntry?
	dea	Funeral	11. Marital Status	12. Was Dece Armed Fo	ident Ever in U		Was Decedent of	Hispanic Origin? ( pan, Mexican, Pue	Specify Yes or No-	14. Race - Americ Black, White,	
98	or It	y Fu	1 Never Married 2 Married	1 ☐ Yes If Yes, Giv	2X No		1 ☐ Yes 🎾 No		110 1 110 211, 010.7	0.7	ite
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N	filed withi Hygiene. other than	e Co	17. Father's Name (First, Middle, La	st)				18. Mother's Na	ame (First, Middle, Maid		
Maryland	should be filed within of Mental Hygiene. marked other than matic event, the M	To B	Frank Russell '	<i>l</i> oung				Gr	ace Beard	,	
ary	2 should and Men le marke aumatic		19a. Informant's Name/Relationship	(Type, Print)					Rural Route Number, Cit		
	# 2 m		Eugene D. Young,	Nephew		423½	East Pat	rick Str	eet, Freder	ick, MD 2	1701
Baltimore,	00-		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from S	20b. State Smit	Place of Dispo	sition (Name of natory or other pla	Sent	Date 20c.	Location - City or To	wn, State Maryland
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Bai	permit. Pages Department of Important: If it any injury or o		21. Signat fre of Funeral Service Lice	ensee Min	L NOC	0021	l. Name and Addr eeney an	d Basfor	d Funeral H treet, Fred	ome 1 M	21701
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	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	_aC \	A						LIVEEN
	Examiner			Due to (	or as a conse	quence of):					
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Вох	eath certif attending for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			1e			23d. Date of delive	iry
Ω.	death e atte	cla	in the past 12 months?	4☐ Pregn	irth 2 Teta ant at time of a		]Ectopic pregnand ]Other (specify) _	:у		Month	Day Year
P.0	by the detached	hys	9 🗌 Unknown	9□ Unkno	own						
S, F	The law fequires that the death certified has been signed by the attending tage 2 should be detached for use a	by F	Part II. Other significant conditions	contributing to de	eath but not res	sulting in the ur	nderlying cause gr	ven in Part I.	23e. Did tobacc	o use contribute to th	ne cause of death?
Records,	been si								1 🗆 Yes	2 □ No 3 □ Prob	ably 4 ⊟triknown
e C	e law r has be je 2 sh	Completed							24a. Was an autopsy		psy findings available inpletion of cause of
		NO.							performed?	death?	
Vital	Physician: 1r this certificate ral director, pag	Be	25. Was case referred to medical examiner?					26. Place of De	eath (Check only one)		
of V	nysic als ce I dire	2	1 Yes 2 10	Hospital: 1 🖂	npatient 2	ER/Outpatien	t 3 DOA Ot	her: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify	<i>(</i> )
		ü	27. Manner of Death 1 ⊟Natural 5 □ Pending	28a. Date of (Montal	of Injury h, Day Yeer)	28b. Time of Injury	28c. Inju Wo	ry at	28d. Describe how in	jury occurred	
<u>s</u>	Attending r death. sctor: After by the fune	catl	2 Accident investigat	on				Yes 2 No			
Division	or Attendate deate Director:	Certification:	3 ☐ Surcide 6 ☐ Could not 4 ☐ Homicide determine	d Zee. Place	of Injury - At h	iome, farm, str	eet, factory, office		28f. Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,
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	To the Hospital within 24 hours a Within 24 hours a To the Funerat Completely filled in	Medical	29a. Certifier 1 -Certifying I (Check only one) 2 Medical Ex	hysician: To the aminer: On the ba and mann	isis of examina	owledge, death ation and/or inv	occurred at the to restigation, in my	me, date and place opinion, death occ	e, and due to the cause surred at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
	Nithin 2 To the comple	Med	29b. Signature and title of certifier	and mann	er stated.		29c. Licen	se number	29d F	Date signed, (Month,	Day Year)
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			30. Name and address of person wh	o completed cause	a of donth /li-	m 23a) /Time	Print	0 100	CV 7	Jan Jan	D12 141 415
	3		DR - TRINA	Completed cause	RANK	- 20a) (Type,	210 6	USINE	SS CENI	TINE DY	10WW, MD
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician August WILLIAM THOMAS McDERMOTT 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner WICOMICO If Under 1 Year Funeral Social Security Number Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1**X**M 2□ F Yrs. Director 025-20-9301 75 1/15/1929 MA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-1 show other traumatic avent, the Neulcal Examinar must be notified at Yes 2 No Director Ocean Pines Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Wood Duck Dr. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give WW 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married WWII 1 Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry t. Pages 1 and 2 shourd be ince-intment of Health and Mental Hygiene. brient: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Engineer Machinery Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward P. McDermott Agnes Whalen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **Betty McDermott** 20 Wood Duck Dr. Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 8/27/04 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crematory Frankford, DE 21. Single Fun Service License 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 23a. Part1. Enter the disease, or complications to a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) andway opathy **Physician** /Medical Examiner artere Sequentially list conditions, any leading to in neclate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a ponsequence of): the attending physician and the dor use as the burial-transit The law requires that the death certificate be executed cancer Due to (or as consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an 2.X No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. D te of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospitel within 24 hours a To the Funerel I 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Me DERMOTT, WElliam

address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) AUG 2 7 2004

E. Welberg MO 106 Milford St.

Registrar's Signature

046536

SAlisbury, Md. 21804

8/26/04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar #26, per physician, 8/27/04 Certificate of Death WCHD, E. Tree No. Amended item 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 25, 2004 0900 M August MONAGHAN JOHN T. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ocean Pines Worcester 4 Fairhaven Court If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye 7-25-28 Birthplace (State or Foreign Country)
 DC 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2□F 76 229-26-9482 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-t show the Medical Examinent wat be notified at 1 Yes 2 No Md. Worcester Ocean Pines Direct 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code filed within 72 hours after death with or Items 23a or USA 21811 4 Fairhaven Court Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Ø Yes 2 □ No
If Yes, Give
Year or Dates: 51-52 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hyglene. other then Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Surveying 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fill then of Health and Mental H tant: It item 27 is marked ott jury or other traumatic even Genevieve O'Brien Louis E. Monaghan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4 Fairhaven Ct., Ocean Pines, Md., 21811 Sarah E. Monaghan Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Department o Important: It any injury or once. Salisbury Crematory 8-29 Salisbury, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ullrich Funeral Home Berlin, Md. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of) **Examiner** "oronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24b. Were aulopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2/2 No 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 Other: 4 Nursing Home 5 esidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No Proupation 3 DOA this After the funeral 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by

Division of Vital Records, P.O. within 24 hours after deat To the Funeral Director:

State Registrar

completely

4 | Homicide

(Check only one)

29b. Signature and title of certifier

29a, Certifier

trey

29c. License number

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anthony

1205 32. Registrar's Signature

31. Date filed (Morth, Day, Year) AUG 2 7 2004 PETER MURPHY

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Records, P.O.
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			1 - For State Registrar		State of Ma	aryland /		artment of F rtificate of		wentai my	Reg. Nø.	004	28963
	Physici /Medie		Decedent's Nam			JRPHY				2. Date of De Month	Day	Year O4	3. Time of Death
	Examir				ive street and number)			4b. City, Town, o	r Location of Death		4c. 0	County of Death	)
			43 Sun of 5. Social Security N	dial Ci		e (In yrs. last b	irthday)	Ocean I		8. Date of Bi	-th	ceste	
	Funeral Director		153-30-9 Usual Residence of	9260	1 <b>⊠</b> M 2□F	65	Yrs.	Months Days	Hours Min.	8-31-3	ay, Year) 38		nplece (State or Foreign untry) NJ
	yland		10a. State	10b. County		10c. City, To	wn or Lo	ocation					10d. Inside City Limits
	e Mar 3a-f si	ctor	Md.	Worces	ter	Ocean	n P	ines			_		1 XYes 2 ☐ No
	with th	Funeral Director	10e. Street and Nu		_			10f. Zip Code				en of What Cou	untry?
	leath is 23	era	11. Marital Status	dial Ci	12. Was Decedent	Ever in U.S.	13.1	21811	isnanic Origin? (Sr	pecify Yes or No	USI	A. Race - Amer	ican Indian
36	2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland is marked other than "natural", or flems 23a or 28a-f show aumatic event, the Maulical Examinar must be notified at	by Fun		ied 2 Married 4 □ Divorced	Armed Forces?  1 XYes 2 1 If Yes, Give Year or Dates:	No	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗷 No	Specify:	Rican, etc.)	1	Black, White	, etc.
5-0036	2 hou	ted	/C-24	15. Decedent's E	Education		a. Deced	dent's Usual Occup	ation		16b. Kind	Whi d of Business/li	
2	within 72 isne.	Completed	Elementary/Seco	, , , ,	College (1-4or 5	5+)	life. L	DO NOT use retired	1)	ung	_		
2	Hygier ther th		12 17. Father's Name	(First Middle Las	(t)		Post	t Produc	18. Mother's Nam	o (First Middle		adcas	ting
and	d be f	To Be		Murphy	,				Martha			,	
Maryland	permit. Pages 1 and 2 should be filled within Department of Health and Mahral Hygiene. Important: If item 27 is marked other than eny injury or other traumatic event, the Mapnes.	ř	19a. Informant's N		(Type, Print)	19	b. Mailin	ng Address (Street					îp Code)
	1 and 2 Health a tem 27 is		Carol A	. Murph	y Spou	ise 43	3 Si	undial (	Cir., Oc	ean Pi	ines,	Md.,	21811
FE Baltimore.	Pages 1 nent of He int: If iten		20a. Method of Dis		Removal from State	20b. Place cemete	of Dispo ery, cren	sition (Name of natory or other plac	ee)	Date	20c. Loca	ation - City or T	own, State
ī Ē	t. Pag rtmen rtant: njury		* 4 □ Donation	5 Other (Spec	ify)	Salis	-	ry Crema		-31	Sali	sbury	, Md.
Ba	permit. Departr Import		21. Signature of Fu	In 331 Service Libe	ensee			Name and Address Llrich E		Homo	D = 10.7		a
			23a. Part L Enter t	he disease, or cor	nplications that caused y one cause on each lin	the death. Do						in, Mo	Approximate
	Physician		shock, or hea Immediate Cause disease or condition	(Final	y one cause on each lin	hoges							Interval Between Onset and Death
	/Medical		resulting in death)	•	Due to (or as	a consequence		Cerc	2mon2				6 MO-IL
	Examiner	_	Sequentially list co	nditions,	b								
7	rted nsit	Examiner	n any, leading to in cause. Enter Under Cause (Disease or that initiated events	erlying and injury	Due to (o. as	a consequence	or).						
ď	be executed sician and burial-transit	Exar	resulting in death)	Last	c. Due to (or as	a consequence	of):						
760.	ite be iysicia ne bur			•	d								
(687	The law requires that the death certificate bate has been signed by the attending physic page 2 should be detached for use as the b	Physician/Medical	IF FEMALE:								- 1		
Box	ath ce	lan/	23b. Was deceden		23c. If yes, outcome	2 Fetal deat		Ectopic pregnancy			23	d. Date of deliv	rery Day Year
0	that the de ed by the a detached	yslc	1 ☐ Yes 2 [ 9 ☐ Unknown		4□Pregnant at 9□Unknown	time of death	5	Other (specify)					
۵	res that igned by be deta	by Ph	Part II. Other signif	ficant conditions	contributing to death be	ut not resulting	in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use	contribute to t	the cause of death?
rds	w require: been sig should be	ed b								18	Yes 2□	No 3 ☐ Pro	bably 4 □Unknown
Division of Vital Records.	e law re has bee	Completed								24a. Was	an	24b. Were auto	opsy findings available ompletion of cause of
a a	ician: The certificate hi ector, page	Com								perfo	med	death?	
Vita	Physician: The rate certificate ral director, pag	Be	25. Was case refer examiner?	red to medical	Hospital			100	26. Place of Deat				
of	Physic this cral dir	5 To	1 ☐ Yes 2 ☐ 27. Manner of Deat			ent 2 ER/O	utpatien		4   Nursing H				fy)
o	ding th. th. After funer	tlon	1 Aatural 2 Accident	5 Pending investigation	28a. Date of Injur (Month, Day	y Year)	Injury	Work	(? Yes 2 □ No	28d. Describe	now injury (	occurred	
<u>:S</u>	il or Attandi after death. Diractor: A	ifica	3 Suicide	6 Could not determined	00	ury - At home, f	arm, stre	eet, factory, office		28f. Location (	Street and i	Number or Run	al Route Number,
Ö	tal or A s after at Dirac	Certification:	4   Homicide		building, etc	c. (Specify)				City or To	wn, State)		
	To the Hospital or Attanding within 24 hours after death or To the Funeral Director: After completely filled in by the fune	ledical (	29a. Certifier (Check only one)	1 Certifying P	hysicîan: To the best of miner: On the basis of and manner sta	examination a	e, death	occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) ar date and p	nd manner as s lace, and due t	stated. o the cause(s)
	Within To the Comp	M	29b. Signature and	title of certifier	10/6	)		29c. License	number	>	29d. Date :	signed (Month,	Day, Year)
			30 No== == 1 · · ·		P	My SK	117	114	428 -	>	8/.	75/0	4
ET	5+1		120.	bert L	completed caus of d	9733	(Type, I	es Muc	y Are	re 4	Berle	-, m	0
	Sta Registr		31. Date filed (Mon	AUG 2	7 2004 32. R Istra	ar s Signature	16	pera	(				

	State of Maryland / Departure	rificate of Death	Reg. 1	0001			
Physician	Decedent's Neme (First, Middle, Last)		2. Dete of Death Month	Day Year 3. Time of Dea			
/Medical	Adelia E. Nic	hols	August 22				
Examiner	4a Fecility Neme (If not institution, give street end number)	4b. City, Town, or	Location of Deeth	4c. County of Death			
ē	Doctor's Community Hospital	Lanham		rince Georges			
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min	. (Month, Day, Yea				
rector	214-16-7770		Nov. 13,	1915 Maryland			
	10a. Stete 10b. County 10c. City, Town or Local	ation		10d. Inside City Li			
Examiner must be notified at by Funeral Director	Maryland Prince Georges Bowie			TXXYes 2□			
2	10e. Street end Number	10f. Zip Code	10g. (	Citizen of Whet Country?			
0	15005 Health Center Drive Room 218B	20716	TT	.S.A.			
Funeral Director		as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer		14. Race - American Indian,			
þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No	Yes Z∏ No Specify:	to Hican, etc.)	Black, White, etc.  Specify: White			
Be Completed	15. Decedent's Education 16a. Decede	nt's Usuel Occupation	16b.	Kind of Business/Industry			
pie	(Specify only highest grade completed)  (Give kilife. Do	nt's Usuel Occupation ind of work done during most of wo O NOT use retired)	orking				
P		etary	Fe	deral Government			
98	17. Father's Neme (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maide				
2	Robert H. Kruhm	Emma	Α.	Oursler			
		Address (Street and Number or Ri					
į		Millstream Drive	e, Bowie, M	aryland 20715			
	20a. Method of Disposition 1 IX Burial 2 ☐ Cremation 3 ☐ Removal from State	tion (Name of atory or other place)		Location - City or Town, State			
ì	4 □ Donation 5 □ Other (Specify) Union Ceme	tery	8/26/04 Bu:	rtonsville, Maryl			
pne.  To Be Comple				ans Funeral Home			
	23a Part 1 Enter the disease or complications that caused the death. Do not enter	00 Annapolis Roa	ad, Bowie, I	Maryland 20715 Approximate			
ian	23a. Part1. Enter the diseese, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the most of dying, soon as sardia	o or roopilatory arrost,	Interval Between Onset and Death			
cal	Immediate Cause (Final	10 1		- 1.4			
er	Immediate Cause (Final disease or condition resulting in death)  a. Acuse Myo (u/	dink infall	0)1071	204/			
وَ ا	Sepsis	ance org:		2 day			
Ē	U	ance of):		201/			
EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	141/					
edical Examiner	that initiated events						
	resulting in deeth) Lest	Bonel		1-2 29			
Z/a	d. ISON WITCH	junes		1-201			
/ Physici	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23b. Did tobacc	co use contribute to the cause of de			
Completed by Physician/M	1. Ca 200 (1)		1 🗆 Yes	200 3 Probably 4 Unkr			
by	Acute Nevince faile						
ieted	Demention		24a. Was an aut performed?	available prior to			
Comple	1) en a 10			completion of cause of deeth?			
, Lo	Nabers mellisus.		1 ☐ Yes	2 No 1 □ Yes 2 □ No			
Be (	25. Was cese referred to medical examiner?	26. Place of Dea	ath (Check only one)				
	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient		fome 5 Residence	6 ☐Other (Specify)			
ü	27. Manner of Deeth 1 Naturel 5 Pending 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury et Work?	28d. Describe how inj	ury occurred			
ati	2 Accident investigation	M 1□Yes 2□No					
Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (Street a City or Town, Ste	and Number or Rural Route Number, te)			
3							
Medical Certification: To	29a. Certifier (Check only  (Check only  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)	ccurred at the time, date and place	a, and due to the cause(	s) and manner as stated.			
Med	one) and menner steted.						
2	29b. Signature and title of certifier	29c. Aicense number	29d. D	Pate signed (Month, Day, Yeer)			
	N. Town M. J.	0-11//0	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	15-200-1			
		chillville Rd	A312	-23-2004 Bowle M ∆20-			
State	31. Dete filed (Month, Day, Year) 22. Registrer's Signature	•					
gistrar	AUG 2 5 2004 Com 15	E)					

DHMH 16 Rev 6/95

			For State Registrar	State of Mary		artment of		nd Mental H	2	nn.	28965		
			Hegistrar     Decedent's Name (First, Middle, I	ast)		Timeate of	Death	2. Date of D	Reg. No	007	3. Time of Death		
à	Physici	an			NETI	HEN Sr.		Month	Day	Year	1915 M		
· W	/Medic Examin		4a. Facility Name (If not institution, g		IVE 11	4b. City, Town,	or Location of	August		2004 ounty of Death	1913		
	"Examir	er	810 Yacht Cl				n Pine				•		
	Funeral				yrs. last birthday	If Under 1 Year	If Under 24	Hrs. 8. Date of B	irth	rceste 9. Birthp			
	Director		215-24-7185	1 M 2 □ F 74	4 Yrs.	Months Days	Hours	Min. Month, I	ay. Year9	Cour	lace (State or Foreign htry) 1D		
	P .		Usual Residence of Decedent										
	show	٠_	10a. State 10b. County		c. City, Town or L					1	0d. Inside City Limits		
	8a-f	cto	Md. Worces	ster	Ocean						1 No 2 No		
	vith th	by Funeral Director	10e. Street and Number 810 Yacht Cla	uh Drivo		10f. Zip Code	•		_	n of What Cour	itry?		
	s 23s	rai				2181			USA				
	er de Itam	n.	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Origir oan, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	0- 14	. Race - Americ Black, White,			
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-52	1 ☐ Yes 2 No	Specify:		S	pecify: Wh:	ite		
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show disal Exantine remails.	ed	15. Decedent's		16a. Dece	dent's Usual Occu	pation		16b. Kind	of Business/Inc	fustry		
7.	n n	Completed	(Specify only highest of Elementary/Secondary (0-12)		(Give	kind of work done DO NOT use retire	during most o	f working			300119		
2	d with	E	12	College (1-401 5+)	Owne	er-Mamag	ger		Sign	n Compa	any		
פַ	e file of the vant,	Be C	17. Father's Name (First, Middle, La	st)			18. Mother's	Name (First, Middle	e, Maiden Si	ımame)			
<u>Jar</u>	uld b Ments rrkad itic e	ToE	Adolph Nethe	∍n			Rut	h Halfpe	enney				
Maryland	sho and h		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ng Address (Stree	t and Number	or Rural Route Numi	ber, City or 1	own, State, Zip	Code)		
Σ	and salth n 27 er tr	3	Sharon C. Netl	т.	The second secon		7.0	r., Ocea	n Pir	nes, M	d., 21811		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28a-f show any injury or other traumatic event, the Marifial Examinating the notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	DRomoval from State	Ob. Place of Disponentery, cre	osition (Name of matory or other pla	100)	Date	20c. Loca	tion - City or To	wn, State		
Ĕ	Pag nent ant: I		'4 □ Donation 5 □ Other (Spec		Salisbu	ary Crem	natory	8-28	Salis	sbury,	Md.		
at	ppartriports		21. Signature of Funeral Service Lic	ensee/	2	2. Name and Addre	ess of Facility						
<b>-</b>	20 = 20	0	DIMO!	M	τ	J11rich	Funer	al Home	Ber	lin, Mo	d.		
			23a Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the ty one cause on each line.	death. Do not en	ter the mode of dyi	ing, such as ce	rdiac or respiratory	arrest,		Approximate Interval Between		
4	Pnysician	0. 1	Immediate Cause (Final disease or condition	ASC	vn –						Onset and Death		
ſ	/Medical		resulting in death)	Due to (or as a cor	nsequence of):								
	Examiner		Sequentially list conditions,	b									
	D #	Examiner	if any, leading to immediate Due to (or as a consequence of):										
	and trans	cam	that initiated events resulting in death) Last	C									
8760,	ate be executed hysician and the burial-transit	Ē		Due to (or as a cor	isequence or);								
87	Attending Physician: The law requires that the death certificate be executed croseth.  actor: After this certificate has been signed by the attending physician and property the funeral director, page 2 should be detached for use as the burial-transit.	dicai	•	d									
Box 6	eath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outcome of pro	ennancy								
å	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at time	Fetal death 3[	☐Ectopic pregnanc☐Other (specify) _	y		230	<ol> <li>Date of delive Month</li> </ol>	ny Day Year		
<u>о</u> .	the de	ysic	1  Yes 2  No 9  Unknown	9□ Unknown	ordeam 5	Other (specify) _							
	that the de ned by the a detached t	4	Part II. Other significant conditions	contributing to death but no	t resulting in the u	inderlying cause gi	ven in Part I.	23e. Did	tobacco use	contribute to the	e cause of death?		
Records,	uires sign	d by						1 🗆	Yes 2 □ i	No 3 ☐ Proba	ably 4 Dunknown		
S	w require been si should t	Completed						24a. Was	20 3		sy findings available		
Be	he lav	E						— auto	psv	prior to con death?	pletion of cause of		
ā	n: Ti	မ လ	25. Was case referred to medical				00.00		ormed? 2 No	1 🗆 Yes	2 No		
5	tending Physician: The Leath. tor: After this certificate hathe funeral director, page	Ω .	examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Ott	har	Death Check onl		70than (Cit	1		
ō	Phy er this eral o	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Yea				ng Home 5 x es 28d. Describe			)		
Division of Vital	nding th. :: Afte	ţ	Natural 5 ☐ Pending 2 ☐ Accident investigat		ir) Injury		rk? ]Yes 2∐No		, ,				
Vis	I or Attendatter deatl	ifica	3 Suicide 6 Could not determine		At home, farm, st	reet, factory, office				lumber or Rural	Route Number,		
	tal or At s after d al Diract ed in by	Certification:	4 - Homeda	building, etc. (3)	эвспу)			City or To	wn, State)				
	To the Hospital within 24 hours a To the Funeral Completely filled		29a. Certifier 1 Certifying I	Physician: To the best of my	knowledge, deat	h occurred at the ti	me, date and p	place, and due to the	cause(s) an	d manner as sta	ited.		
	ha H in 24 ha F plete	Medical	one)	eminer: On the basis of exam and manner stated.	mination and/or in	vestigation, in my t	opinion, death	occurred at the time,	date and pla	ace, and due to	the cause(s)		
	with To I	2	29b. Signature and title of certifier			29c. Licens	se number		29d. Date s	igned (Month, E	Day, Year)		
			( ) elter .	Maron M	)	Hoo	1582	4	8	124/0	1		
-	- 1/11			o complete ause of death		Print)							
/	10+1		Jeff Matzo		714 Hea	Harry &	mive	Berun	MD 8	1817			
	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 2 7	2004 32. Pegistrar's S	ignature	ا مد ا							
	riegisti	ar ·	1100001	LUCT KREARS	IN GO	MARKE!							

	•			ype or Print in B State of Maryland						-		_	ble.										
			1 - State AMEND#19aperINF9,			tificate				ioniai i i j	Reg. N	100		200	00								
		Ш	Decedent's Name (First, Middle, Last)							2. Date of De	eath	-	- Albania	3. Time o	of Death								
	Physici /Medic		Leonard Plotkin							Month August		ay 0 • 20	Year 004	07	:00P <sup>M</sup>								
1	Examin		4a. Facility Name (If not institution, give st.	reet and number)		4b. City, 1	Town, or	Location o	of Death			c. County											
			Suburban Hospital				thes		Od Lies			ontgo											
	Funeral Director		207 10 1705	7. Age (In yrs. I	Yrs.	If Under Months	Days	If Under a	Min.	8. Date of Bi	ay, 19	28	9. Birth	York	or Foreign								
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	r, Town or Lo	cation							T-	10d. Inside C	City Limits								
	within 72 hours after death with the Maryland ane. than 'natural', or Itema 23a or 28a-f show than Madisal Examinar must be notified at	Ď1	Maryland Montgomery	, Ro	ckvill	P								1 🗆 Yes	s 2 ∏No								
	r 28a	Directo	10e. Street and Number		10f. Zip	Code				10g. Citizen of What Country?													
	th with	alD	11430 Strand Dr. #11		20	852				U	.S.A.												
	ema era	Funeral		<ol><li>Was Decedent Ever in U. Armed Forces?</li></ol>	S. 13. \	Vas Deced	ent of Hi	ispanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	0-		e - Ameri	can Indian, etc.									
36	or it	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1A∑Yes 2 DNo If Yes, Give Year or Dates: WWII		1□ Yes 2		Specify:				Specify	,.	Thite									
Ö	hour turai	ed b	15. Decedent's Educa			Decedent's Usual Occupation					16h	Kind of Bu											
15	iln 72 n "na Nedic	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give	(Give kind of work done during most of work life. DO NOT use retired)			t of worki	ng	100.	Talle or Be	31110332111	idu3ii y									
21215-0036	d with giene ar tha	To Be	To Bo	mo:	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Electrical Engineer			eer	. U.		S. Government		ment								
	al Hy d oth			17. Father's Name (First, Middle, Last)							ame (First, Middle, Maiden Sur			ımame)									
Maryland	Meni Meni			Charles Plotkin					Anna		omberg												
Mar	12 sh h and 7 Is m traum			Harriette K. Plotki									City or Town, State, Zip Code)										
Baltimore, N	Healt Healt ther						Harriet Plotkin/Wif		1143 lace of Dispo emetery, cren					Rockvi		_		own, State					
	A Single		1 XBurial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)		<sub>emetery, cren</sub> ean Me			(e) (8)	3/23/	/2004		ey, M											
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itema 23a or 28a-1 show any injury or other traumatic evant, the Medical Examination at the confiled at once.		21. Signature of Funeral Service Livenses					1		nes-Rin													
	Frrysician /Medical Examiner								23a. Part   Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Acute Myocardial Infarction Due to (or as a consequence of):  b. Arterialsclerotic Cardiovascular Disease										Spri	Approxima Interval Be Onset and	ite itween		
	certificate be executed nding physician and use as the burial-transit	cian/Medical	cian/Medical	cian/Medical	cian/Medical	cian/Medical	an/Medical	O	_	_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequ	ienca of).										
.O. Box (	death certif e attending od for use a								IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic, If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pre Other (spe						23d. Date Mor		•	Year		
ص	requires that the reen signed by th hould be detache	by Pr	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the ur	nderlying ca	ause give	en in Part I.		23e. Did	tobacco	use contr	ibute to t	he cause of	death?								
rds	w requires that been signed I should be det	ed b	Hypertension							1 🗆	Yes 4	No No	3 🗌 Prot	oably 4 🗌	Unknown								
Vital Record	S S C	ompleted								24a. Was				psy findings									
Ĕ	The ate h page	Com								perfo	ormed? 2X N	d	leath?										
/ita	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?							(Check only													
	Physician: rthis certific ral director,	70	1 □ Yes 2X No		ER/Outpatien					me 5 Resi				<i>(y)</i>									
UC	ding F	lon	27. Manner of Death  1 X Natural 5 Pending  2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	8c. Injury Worl	k?		28d. Describe	now inju	ary occurre	30										
Division of	To the Hospital or Attending Physician: within 24 hours elter death. To the Funeral Director: After this certific completely illied in by the funeral director,	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	M 1 ☐ Yes 2 ☐ No  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Aural Route Number, City or Town, State)				mber,											
	ne Hospital	edical (	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin	cian: To the best of my known or: On the basis of examination and manner stated.	wledge, death tion and/or in	occurred a vestigation,	at the tin in my o	ne, date an pinion, deat	d place, a th occurre	and due to the ed at the time,	cause( date ar	s) and mai nd place, a	nner as s ind due ti	tated. o the cause(	s)								
	To the P within 2 To the F complete	Me	29b. Signature and title of dertifier	18 19	son	29c	. License	e number			29d. D	ate signed	(Month,	Day, Year)									
			) the	// sadd	011	D0	0119	921			08/21/2004												
	20		30. Name and address of person who cor John A. Galotto, N	D 5225 Pooks			t. 1	l−A Be	ethes	sda, MD	208	314											
	Sta Registi		31. Date filed (Month, Day, Year) AUG 24 20	32. Registrar's Signa	ture &	Sp	rock	2															

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No	ton to the second			
Physician /Medical	Mary Mario Boddick	2. Dete of Deeth Month De September	Yeer 2:00 P.M.			
Examiner	4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Loc 1557 Baust Church Road Union Brid	The second second	c. County of Death Carroll County			
Funeral Director	5. Social Security Number  6. Sex 1 M 2X F  7. Age (In yrs. lest birthday) 6. Sex 7. Age (In yrs. lest birthday) 6. Sex Months Days Hours Min.	8. Date of Birth (Month, Dey, Year Mar. 8, 19	9. Birthplace (State or Foreign Country)			
Maryland a-f ahow died at	Usuel Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   Maryland   Carroll County   Union Bridge		10d. Inside City Limits 1 □ Yes 🎉 No			
Uffer death with the Mainter death with the Mainter mast be notified the result of the Color Funeral Director	10e. Street end Number 10f. Zip Code 1557 Baust Church Road 21791	10g. Citizen of Whet Country? United States				
02( urs a by	11. Marital Status  1 ☑ Never Married 2 ☐ Married  1 ☐ Wes Decedent Ever in U,S.  Armed Forces?  1 ☐ Yes 2 ☒ No  If Yes, specify Cuban, Mexican, Puerto R  1 ☐ Yes, Give  Year or Dates:	city Yes or No- lican, etc.)	14. Race - Americen Indian, Black, White, etc. Specify: White			
vithin within ene.	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  G  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  COOK	g	16b. Kind of Business/Industry  meals preparation			
aryland 212: should be filed within the Mental Hyglene. marked other than imetic event, the M To Be Comp	17. Father's Neme (First, Middle, Last)  18. Mother's Name	(First, Middle, Maide				
Maryland of 2 should be file tht and Mental Hy 27 is marked other traumatic event To Be (	Celius Weaver Reddick  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rurel	ene Crum  Route Number, City	or Town, State, Zip Code)			
ore, Mest and 2: of Health at litem 27 is rother trau	Martha E. Hauver / sister 13841-B Pryor Road T	hurmont, M	Maryland 21788  Location - City or Town, State  Learner Maryland			
Baltimos permit. Pages Department of Important: If it any Injury or o	Of Cinneture of Europea Compine Ligarities	les Funera				
D.P.B.	23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.		Approximate Interval Between			
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):		Onset and Death			
death certificate be axecuted death certificate be axecuted of attending physician and ad for use as the burial-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (u. as a consequence of):  ConQUSTALL NEUTTA  Due to (or as a consequence of):  https://documents.com/documents/document	ilux				
P.O. BOX nat the death cen d by the attendic latached for use Physician/	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco	o use contribute to the cause of death?			
		1  Yes 2 No 3 Probably William				
ecorc aw requii is been s 2 should		24a. Wes en euto performed?	24b. Were autopsy findings available prior to completion of cause of deeth?			
tal Ro		1 □ Y € 2	No 1 Yes 2 No			
Of Vital Physician: 7 rthis cartificat and director, p	25. Was case referred to medical examiner?  1  Yes 25 No	(Check only one)  e 5 Residence	6 □Other (Specify)			
VISION OF Attending Phy or death. ector: After this by the funeral of	27. Maprier of Deeth  1. Neturel 5 Pending (Month, Dey Year)  28a. Date of Injury (Month, Dey Year)  28b. Time of Injury at Work?  1 Yes 2 No	28d. Describe how injury occurred				
Ital or its after in led in Cert	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 21	Bf. Location (Street a City or Town, Stat	reet and Number or Rural Route Number, n, State)			
Ne Hospital n 24 hours: Ne Funeral pletaly filled	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, er (Check only one)  Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred end manner stated.					
To the within 2 To the comple	29b. Signature and title of certifier  29c. License number  2000007	29d. Da	ate signed (Month, Day, Year)			
Z	30. Name and edgress of person who completed cause of deeth (Nem 23e) (Type, Print)  Diana Juliano, M.D. 610 Solarex Court Fr	ederick, N	Naryland 21703			
State	31. Date filed (Month, Day, Year)  32. Refistrer's Signature	•				

		For State Ragistrar		aryland / Dep <i>Ce</i>	rtificate of L				Reg. No.	04	28968
Physicia	an	1. Decedent's Name (First, Middle, L.						Date of De     Month	Day	Year	3. Time of Death
/Medic	al	Bertha Mary Reve			4b. City, Town, or	Longtion	f Dooth	August		2004 by of Death	1059 M
Examin	er	Atlantic General			Berlin	Location	n Death			ester	
Funeral			Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Bir		9. Birthr	place (State or Foreign
Director		221-14-9623	1□M 2\XF	79 Yrs.	Months Days	Hours	MILL.	8. Date of Bir (Month, Da Mar. 30	7,1925	New	York
and	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation					1	10d. Inside City Limits
Maryl Hadyl	Ď	MD Worcest	er	Berlin							1 ☐ Yes 2 🕅 No
5-UU36 72 hours after death with the Maryland natural; or tems 23a or 28a-f show dical Examiner must be rigified at	Funeral Director	10e. Street and Number			10f. Zip Code				10g. Citizen of	What Cour	ntry?
th wit	a D	10439 Assateague	Road		218	311			USA	1	
r dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Orig	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	- 14. Ra Bl	ce - Americack, White,	
Z1Z13-UU30 d within 72 hours after giene. er than "natural", or if	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎛 Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🛣 No	Specify:			Spec	ify: Wh	ite
2 hours	ed t	15. Decedent's B	ducation	16a. Dece	dent's Usual Occupa	ation			16b. Kind of I		
Media 7	ple	(Specify only highest g. Elementary/Secondary (0-12)	rade completed) College (1-4or 5	(Give	kind of work done of DO NOT use retired	luring most )	t of workii	ng			
filed within Hygiene, ther than "	Completed	11			lomemaker					n Hon	ne
be file d oth	Be	17. Father's Name (First, Middle, Las	t)						Maiden Suma	me)	
should Ind Men	ပ	Purnell Mitchell  19a. Informant's Name/Relationship	(Time Print)	10b Maili	ng Address (Street a	Mary			Ciby of Tour	Ctato 7is	Code
Mary larro nd 2 should be file lith and Mental Hy 27 is marked oth rtraumatic event		Theresa Dailey/D		1	Assatea;						(000)
re, s 1 an Heal tem 2 other		20a. Method of Disposition		20b. Place of Dispo cemetery, cre				ate	20c. Location		own, State
Pages ent of		1 ØBurial 2 ☐ Cremation 3 ]  4 ☐ Donation 5 ☐ Other (Spec		Oddfellow		i	3/30/	2004	Seafor	d. De	laware
Dattimore, Maryland Z1Z13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "instural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational be notified at once.		21. Sign a use of Funeral Service Ucc	1º 30	11. 2	Name and Address 212 Old Oc	s of Facility	Home	, P. O.	Box 3	171	
		23a. Part1/Enter the disease, or cor shock, or heart failure. List only	nplications that caused	the death. Do not en						. у , гп	Approximate Interval Between
W760, Arte be executed Wedical Examine purial-transit	lical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, Leaving to animodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or a)	a consequence of):  wonury a consequence of):	failune Kolen	ra					
VISION OT VITAL RECORDS, P.O. BOX 68/6U, Attending Physician: The law requires that the death certificate be executed reasth. reactor: After this certificate has been signed by the attending physician and ector. After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			- 144 - 177 - 177 G 1830 - 178 - 1		ate of delive	ery Day Year
ires that		Part II. Other significant conditions Chrowic Obst		$\bigcirc$	nderlying cause give	en in Part I. 2010		23e. Did to	obacco use cor	tribute to th	ne cause of death?
w requir been si should	etec	1	ria, My		W2 7	انده د	<del>/-</del>	24a. Was	an 24h	Were auto	psy findings available
On Or Vital Records, ding Physician: The law requires t h. Atter this certificate has been signe funeral director, page 2 should be o	Completed by	Renal Tres	Spicien	0.	rany A	of I	rec	autor perio	sv	prior to co	mpletion of cause of
Vital F ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	100		(Check only o	ne)		
Phys rthis ral dir	- To	1 ☐ Yes 2 Z No 27. Manner of Death	1 ☐ Inpatie	~	IL 3 DOX	4   190	rsing Hor		dence 6 🗆 Ot		y)
dlng f th.	tlon	1 Accident 5 Pending investigation	(Month, Da	y Year) Injury	Work	:?` /es 2 □ l			,,		
or Attending after death.  Director: After in by the fune	Certification:	3 Suicide 6 Could not determine	be One Disease(Ini	ury - At home, farm, st c. (Specify)	reet, factory, office		2	28f. Location (5 City or Tox		ber or Rura	al Route Number,
To the Hospital or Attention within 24 hours after death To the Funeral Director: completely filled in by the	cal Ce	29a. Certifier 112 Certifying F	hysician: To the best miner: On the basis o	of my knowledge, deat	h occurred at the tim	e, date and	d place, a	and due to the	cause(s) and m	anner as si	tated.
the hin 24 the f	Medical	29b. Signature and title of certifier	and manner sta	ated.	29c. License				29d. Date sign		
To With		A CONTRACTOR OF COLUMN			D.SX	75.1			0/2	The	P
		30. Name a M address of person who	completed cause of d	leath (Item 23a) (Type	Print)	, -0			8100	10	
		/ 1	, M.D., 12			erlin	, MD	21811			
		31. Date filed (Month, Data Year)		ar's Signature							

			For State Registrar	State of Ma	aryland / Dep	artmen ertificat			ind M		giene Reg. No.	004	289	169
		7 4	1. Decedent's Name (First, Middle, Last	t)						2. Date of Dea		Vear		of Death
	Physici /Medic		Carol Galla	gher Re	ed					Aug.	28	2004	5:00	) Рм
	Examir		4a. Facility Name (If not institution, give					Location o			4c. C	ounty of Deat		
÷.	3 7	-	1695 Armistice					ttsv				Carro		
	Funeral Director		5. Social Security Number 6. Security Number 15 - 92 - 7175	9X □M 2X∏ F 7. Age	e (In yrs. last birthda) 40 Yrs.	Months		If Under 2 Hours	Min.	8. Date of Birth (Month, Day May 3	, 196	9. Birti 4 Was	hplace (State untry) h., D	or Foreign
.0.	P		Usual Residence of Decedent		10.00								nui.	
	arylar ehow	_	10a. State 10b. County		10c. City, Town or I								10d. Inside	City Limits s 2 No
	Se-f	cto	MD Carro	11	Marri			е						5 2 1110
	or 2	듬	10e. Street and Number	T.7		10f. Zip		101			10g. Citize	n of What Co	untry?	
	s 236	rai	1695 Armistice	Way  12. Was Decedent 6	Ever in II S 12	Was Door		104	-i-2 (Ca	ait. Van as Na	14	USA Race - Ame	rican Indian	
	ltem Item	Funeral Director	11. Marital Status 1 ☐ Never Married 2 🛣 Married	Armed Forces?	do				, Puerto	ecify Yes or No- Rican, etc.)	14	Black, White		
36	urs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	21 <b>X</b> No	Specify:			S	ресіту: Wh	ite	
ŏ	in 72 hours after death with the Maryland "neturel", or Items 23c or 28e-f ehow colcal Exemiter Hat be rediffed at		15. Decedent's Ed	ucation	16a. Dec	edent's Usu	al Occupa	ition			16b. Kind	of Business/	Industry	
215	- 3	pie	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5	+) (Giv	e kind of wo DO NOT u	rk done d se retired,	u <i>ring</i> most I	of work!	ng	U.	S. Go	vt.	
21		Completed	12			itrac	t Sp					A.S.A	•	
nd	be filled stal Hygi d other event, II	Be	17. Father's Name (First, Middle, Last)							(First, Middle,		,		
yla	should be and Mental marked o umatic eve	2	James J. Gall							Gentil				
Maryland 21215-0036	2 sho and is ma reum		19a. Informant's Name/Relationship (T							I Route Numbe				
e)	ss 1 and 2 should by Health and Meritem 27 is marke other treumatic		Christopher Re 20a. Method of Disposition	ed / spo	use 1695				-			tion - City or		1104
Ö	it of the street		1 Burial 2 Cremation 3 □		20b. Place of Disp cemetery, cr			1	8-3	-		•		MD
Baltimore,	rt Pe		' 4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Lice		Gate of					04 b all Fu	llve	r Spr	ing,	MD.
Ba	permit. Pages: Department of H Importent: If ite any injury or ot		21. Signature di Putta il Service Licent			512						MD. 2		
		_	23a. Part1. Enter the disease, or comp	olications that caused	the death. Do not e							IID. Z	Approxima	ate
			shock, or heart failure. List only of Immediate Cause (Final	one cause on each lir	10.								Interval Be Onset and	
	Pnysician /Medical		disease or condition resulting in death)	a. Breas	a consequence of):							-		
г	Examiner				2 33.103423.103 3.7.2									
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):									
	be executed sician and burial-transit	Examiner	that initiated events	c										
oʻ	e exe	EX	resulting in death) Last	Due to (or as	a consequence of):									
8760,	ate be	lical	(	d										
Ö	leath certifica attending ph I for use as t	Physician/Med	IF FEMALE:	00-16										
Вох	ath o	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal death 3	□Ectopic p					230	<ul> <li>d. Date of deli</li> <li>Month</li> </ul>	very Day	Year
0	at the de by the a stached i	ysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time or death 5	Other (sp	эөспу)				1			
Φ.	de ad		Part II. Other significant conditions co	ontributing to death by	ut not resulting in the	underlying o	ause give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of	death?
ds,	uires signe ld be	d by								1 🗆 Y	es 2	No 3⊟Pro	bably 4	Unknown
COL	w require been sig should b	lete								24a. Was a	an I	24b. Were au	tonsv findings	s available
Re	0 5 6	Completed								autop: perfor	med?	prior to death?	ompletion of	cause of
Vital Records,		CO	25. Was case referred to medical					26 Place	of Dooth	1 ☐ Yes	2 No	1 🗌 Yes	2 No	
	Physician: this certific ral director,	o B	examiner?	Hospital: 1   Inpatie	nt 2 EP/Outpatii	ent 3 DC	Othe	and the same of th	rsing Hor	- /		Other (Spec	eify)	
J Of		n: T	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time		28c. Injury Work			28d. Describe h				
io	Attending r death, ector: After by the funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		injury	М		es 2×1	No					
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, s	treet, factor	y, office			28f. Location (S City or Tow		Vum <i>ber</i> or Ru	ral Route Nu	m <i>ber</i> ,
	lospitel or hours afte unerel Dii								1					
	T 4 1 2	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	ysician: To the best of iner: On the basis of	examination and/or	ath occurred investigation	at the tim , in my op	e, date and inion, deat	d place, a h occurr	and due to the c ed at the time, d	ause(s) ar late and pl	nd manner as ace, and due	stated. to the cause	(s)
	thin 2 thin 2 the imple	Med	29b. Signature and title of certifier	and manner sta	100.	290	c. License	number		2	29d. Date s	signed (Month	Day, Year)	
	with Con		> Very Chr	)				593	25			8127		
			30. Name and address of person who d	completed cause of d	eath (Item 23a) (Tuo	a Print\					-		1	
	CK (5)	1	Johns Halling (Month Day Year)	1650 Q(1	ears st	IM 5	3. 1	3alt	TE	red St	0 71	1231 S. M	D.	
1	Sta	ite	OT. Bato mod (mbrilli, Day, 10ar).	g 1 logistic	ar's Signature						- u 1 11	11 .	·	
	Regist		AUG 3 0 2004	El Sure	, # Lo	cole								

		•	For State	State of Ma				1ental Hygier	0001	
			Registrar		<i>CE</i>	ertificate of	Dealli	Reg. I	No.	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, La					Month	Day Year	
	/Medic			IICI C	ıth	1 4 60 T		August 26		12:35 p <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, given			4b. City, Town, o	Location of Death		4c. County of Dea	_
			2302 Crestlawn A			Chever		D. Dave of Birth		George's
	Funeral		5. Social Security Number 6.	177 M OF THE	(In yrs. last birthday 82 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea	1022 No.	thplace (State or Foreign ountry)
М	Director	1	116-03-8749 Usual Residence of Decedent	-	02			Aug. 14,	1922 Ne	w York
	and *	-	10a. State 10b. County		10c. City, Town or I	_ocation				10d. Inside City Limits
	f sho	ō	Maryland Prince	George's	Cheven	1y				1X Yes 2 □ No
	28e-	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
	with the or		2302 Crestlawn	Avenue		207	85		U.S.A.	
	within 72 hours after death with the Maryland jiene. Than "naturel", or items 23e or 28e-f show I're Medical Evarither mast ke notified at	Funeral	11, Marital Status	12. Was Decedent E	ver in U.S. 13	Was Decedent of H			14. Race - Am	
_	ter d	표	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give	0 1944-			Rican, etc.)	Black, Whi	
3.15-U036	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1946	1 ☐ Yes 2 🕅 No	Specify:		Specify: W	hite
Ş	72 hor	Completed	15. Decedent's E	ducation		edent's Usual Occup		ing 16b	Kind of Business	/Industry
2	within 7 iene. 'then "n	p b	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5-	life.	DO NOT use retired	f)	9		
7	d wit	Š	12			l Spinner			<u>rivate B</u>	usiness
פ	be filed stal Hygi ed other event, I	Be	17. Father's Name (First, Middle, Las	)			18. Mother's Name	e (First, Middle, Maid	len Sumame)	
<u>a</u>	Aents Aents rked tice	10	Jacob Ruth				Hedwig V	Veinert		
Maryland	2 should be f and Mental I Is marked or reumatic eve		19a. Informant's Name/Relationship	Туре, Print)	19b. Mai	ling Address (Street	and Number or Aur	al Route Number, Cit	y or Town, State,	Zip Code)
	24 and 12		Geraldine Mae Rut	h – Spouse				. Cheverly		
Baltimore,	of Head		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [	TRomoval from State	20b. Place of Disp cemetery, cr	oosition (Name of ematory or other plac		Date 20c.	Location - City or	Town, State
Ĕ	Page nent nnt: If		`4 □Donation 5 □Other (Spec		Congress	ional Cemet	ery   8/31	/2004 Wa	shington	, D.C.
ᆵ	mit. partn porte y inju		21. Signature of Funeral Service Lice	nsee	1	22. Name and Addre	ss of Facility Ga	sch's Fun	eral Hom	e, P.A.
ñ	permit. Pages 1 a Department of He Importent: If flem eny injury or othe		laudelle	Daxhi	Jahning 1	739 Balti	more Aven	ue, Hyatt	sville,	MD 20781
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	plications that caused	the death. Do not e	nter the mode of dyir	g, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Pnysician	- 0	Immediate Cause (Final disease or condition		Cardio N	(vonathy				Onset and Death Years
	/Medical		resulting in death)	a	consequence of):	Гуориспу				Tours
	Examiner		A CONTRACTOR OF THE STATE OF TH	Coronary	Artery I	)isease				Years
		Je.	Sequentially list conditions, and a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury		consequence of):					
	outed ad ransli	Examiner	that initiated events	c. Diabetes						Years
o,	an ar	Ä	resulting in death) Last	Due to (or as a	consequence of):					
09/8	tate be executed thysician and the burial-transit	dical		d						
وَ	ng ph	Med	IF FEMALE:							
X R O	death certific e attending p id for use as i	an/	23b. Was decedent pregnant	23c. If yes, outcome of		□Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
	0 0 0	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at i	time of death 5	Other (specify)				54,
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	res that igned I be det	ρ	Part II. Other significant conditions		it not resulting in the	underlying cause giv	en in Part I.			robably 4 Unknown
ב	w require been si should t	ted	Chronic Renal Fa	llure				10.163	- 1	Todably Todable
ပ္ပ	The law requires that the tte has been signed by the bage 2 should be detache	Completed	<u>Hemodialysis</u>				<del></del>	24a. Was an autopsy	prior to	utopsy findings available completion of cause of
ĭ		Con						performed 1 ☐ Yes 2 🔀		2 □ No
Vital Records,	u <b>clen:</b> Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					h (Check only one)		
	Physic this ceral dire	ဥ	1 ☐ Yes 2X No		nt 2□ER/Outpati		4   Nulsing no	me 5 🛛 Residence		ecify)
	fe fer	ü.	27. Manner of Death  ¹ ⊠Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time Yea <i>r)</i> Injury	Wor	k?	28d. Describe how in	njury occurred	
<u> </u>	Vttendi death. ctor; A y the fu	cati	2 Accident investigati				Yes 2 □ No	00/ 1		1 D 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Division of	l or Attend after death Director: ,	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ry - At home, farm, s . (Specify)	street, factory, office		28f. Location (Street City or Town, St		urai Houte Number,
	Hospitel or Al 24 hours after of Funerel Directely filled in by				La Company	Ab		mand along 4 = 46	(a) and	a atata d
	Hos 4 h Fur iely	edical	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of	examination and/or	ath occurred at the tir investigation, in my o	ne, date and piace, pinion, death occur	and due to the cause red at the time, date :	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifier	and manner sta	ieu.	29c. Licens	e number	29d.	Date signed (Mon	th, Day, Year)
6	7 ¥it		250. Signature and prie or certifier	Alle	////	,				
			Manha	16/10	i Mil		10287	Au	gust 27,	2004
1	2/10/11/		30. Name an vaddress of person who				T71. 2	DC 00:	010	
ار ا	1199		H. Brandis Marsh 31. Date filed (Month, Day, Year)	, MD 106 ■2. Registra	rving St ur's Signature	reet, NW,	wasningt	on, DC 20	710	
	Sta Registr		AUG 3 0 200	4 Klades	r's Signature	wer .				
			MAG -							

# Louise Rawlings

1.
68760,
Box
P.O.
Records,
f Vital
<b>Division</b> o

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			Amend item 1 per	phys g835	9-10-04	ytificate	of Death		Reg. No.	ML	28971
	Physicia	an	1. Decedent's Name (First, Middle, Las	st)			-	2. Date of I		Vana	Time of Death
Storage	/Medic		Louise Rawling		Fannie Ra	wlings		Augus			7:10pm
	Examin	er	4e Facility Name (If not institution, give				4b. City, To	wn, or Locetion of De	ath 4c. Count	y of Deeth	
			GENESIS LA PLA			) If Undar 1		PLATA	СН	ARLES	
	Funeral		5. Social Security Number 6. S	ex / Age ☐M 2☐XF	(In yrs. last birthday		Days Hours	Min. (Month,	Day, Year)	9. Birthplac	e (State or Foreign
	Director		577-01-5998 Usuel Residence of Decedent		92 Yrs.			JAN.	6,1912	WASHI	NGTON, D
dend	M 14		10a. State 10b. County		10c. City, Town or L	ocation				10d.	Inside City Limits
7		ğ	MD CHAR	LES	LA PLA	ΑΤΑ					1 X Yes 2 □ No
ţ	128	Director	10e. Street and Number		211 2 112	10f. Zip (	Code		10g. Citizen of	What Country	?
, ×	ag ag	읖	1 MAGNOLIA DR	TVE			20646		T T	C A	
de at		Funeral	11. Marital Status	12. Was Decedent Ev	er in U,S. 13.	Was Decade		in? (Specify Yes or I Puerto Rican, etc.)		S - A - ce - American	
5-0020 72 hours after death with the Maryland	net nous area deau with the maryer natural, or frems 23e or 28e-1 show ndical Examiner must be notified at		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No If Yes, Give		1 Tes, specin		Puerto Hican, etc.)	Specii	rck, White, etc.	
0200-61215 d within 72 hours at	in in in in in in in in in in in in in i	of by	3 ☑ Widowed 4 □ Divorced	Year or Dates:	10+ D					WHI:	
<u>ה</u> מ	- 4	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	dent's Usuel kind of work DO NOT use	done during most	of working	16b. Kind of B	lusiness/Indus	iry
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0 =	atal Hygiene.		17. Father's Name (First, Middle, Last)			IOMEMA		's Name (First, Midd		HOME	
Maryland	marked other matic event,	To Be	FREDERICK O.	EVERHART				OUISE FRA			ZEMNED
aryla	end Men is marke sumatic	-	19a. Informant's Name/Relationship (7		19b. Mail	ing Address (		r or Rural Route Num			
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ຄຸ້ <u></u>	f Haal fem 2 other	r	20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition /Name	of	Date	20c. Location		
Saltimore,	0 = = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		CEDAR H			b 2 04	CITTOR	ANID M	D
	ortant: Injury	-	21. Signature of Funeral Service Licen:				Address of Facility	9-2-04	SUITL	AND, M	D
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DI	hysician		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each line.	2		o. ayınığı addın 20 t	arolas or respiratory	u.11001,	int	erval Between
	/Medical		Immediate Cause (Final	Anna		1000		5 2 2 2			Emale
<b>₽</b> E	xaminer		disease or condition resulting in death)	a MON AV	ue to (or as a conse		-4C076	canos:	77		117.0
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death certificate be executed	g physician and as the bunal-trensit	Examiner	Sequentially list conditions.	0.	ie to (or as e conse		141172.10	0.3200	CI stre 1	747151F	F NIOLO
O	ian a unal-t	<u> </u>	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury								
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DOX	attandin I for usa	Physician/M		d							
	tha a	Sic	Part II. Other eignificant conditions co	ntributing to death but r	not resulting in the u	ınderlying cau	se given in Part I.	23b. Die	i tobacco use co	ntribute to the	cause of death?
that the	d by	=						1 🗆	Yes 2□ No	3 Probabi	y 🍇 Unknown
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requiras	peen	Completed						24a. wa per	s an autopsy ormed?	availat	autopsy findings ble prior to ation of cause
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VILAI DE!	certificata harector, page	Re	25. Was cese referred to medical examiner?	Hospital:	2 ER/Outpatie		Other: 4 Nur	sing Home 5 Res			
Ol VII DE Physician: The lav	this certificata he	lo Be	examiner? 1 ☐ Yes 2 🕱 No	Hospital:	Ont Time	4 20-					
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DHMH 16 Rev 6/95

		State of Maryland		ate of Death		Reg. No.2004	28972
Physicia	1. Decedent's Name (First, Middle, Las	t)			2. Date of Dea		3. Time of Death
/Medica	CHARLES NOLAN				Sept.	1, 2004 ar	4:50PM
Examine				4b. City, Town, o	Location of Deeth	4c. County of Dee	th
	10640 DEACON I		ation of Hilling	WHITE P		CHARLE	
Funeral Director	5. Social Security Number  213-24-2847  Usual Residence of Decedent	7. Age (In yrs. last	Yrs. Month		. (Month, Day		hplace (State or Foreign nuntry) ARYLAND
land	10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
tha Marylan 28a-f show notified at	MARYLAND CHAR	LES	WHITE PI	LAINS			1 ☐ Yes 2√∑ No
offer death with the Me witherne 23e or 28a f orfer must be notified	10e. Street end Number			Zip Code		10g. Citizen of What Co	untry?
h with	10640 DEACON R	OAD		20695		U.S.	Δ
daat	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dec	cedent of Hispenic Origin? ( pecify Cuban, Mexican, Pue	Specify Yes or No-		rican Indian,
020 urs	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: 1950 —	4□ V	2/No Specify: ,	no Alcan, etc.)	Specify	e, etc. HITE
ind 21215-00 be filed within 72 hou tal Hygiene. If other than 'nature event, the Medical Bo Commission	15. Decedent's Ed		16a. Decedent's Us	sual Occupation	445-	16b. Kind of Business/	
21.	(Specify only highest green Elementery/Secondary (0-12)	Collège (1-4or 5+)	life. DO NOT	work done during most of wo use retired)	orking		
d 21 filed wi Hygien ther th	6		MAINTE	NANCE WORK	ER S	SAVINGS &	LOAN
and 2	17. Fether's Neme (First, Middle, Last)			18. Mother's Na	me (First, Middle, i	Maiden Surname)	
arylan should be nd Mental marked o umatic every						RICE WILL	
Mar 12 sho h end is m resum	19a. Informant's Name/Relationship (7)			ess (Street and Number or F			
CENL	20a. Method of Disposition		ce of Disposition (N	EACON RD.,		AINS, MD 20c. Location - City or	20695
<b>→</b>	1  Burial 2  Cremation 3  □ 4  Donation 5  □ Other (Specify	Removal from State	netery, crematory or	rother plece) HURCH CEM.		POMFRET,	
Baltimo	21. Signature of Funeral Service Licens		22. Name	and Address of Facility MOND FUNER			
	Muhal	V. Some	IA	PLATA, MAR	AL SERV. VIAND	20646	
COLUMN TO SERVICE	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. ne cause on each line.	Do not enter the mo	ode of dying, such as cardia	c or respiratory arm	est,	Approximate Interval Between
Fhysician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	RECTA		igmoin		1	Onset and Death  Five WKS
/B = E			72				
iceta be assected physician and s tha burial-trensit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequence of	r):	***************************************		
68760, tificeta be axe g physician a es tha burial-	that initiated events resulting in death) Last	Due to (or as	s e consequence of	):	, , ,		
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O. E. daar	Part II. Other eignificant conditione con	ntributing to death but not resulting	ng in the underlying	cause given in Part I.	23b. Did to	bacco use contribute	to the cause of death?
S, P.O. BOX se that the death can gned by the ettendir ba deteched for use by PhysicianA	LIVER MI	IZ ATENE	2				obably 4 Unknown
aw raquir s baen si 2 should					24a. Was a	ned? a	Vere autopsy findings vailable prior to ompletion of cause f death?
f Vital Recystolan: The law scartificate has director, page 2					1 □ Ye	es 2152No 1	□Yes 2□No
Vital I				26. Place of De	ath (Check only one	e)	
	examiner? 1 Yes 25 No		VOutpatient 3□ D	Ott		nce 6 □Other (Spec	ify)
n O n og Ph ttar thi narel narel 100. T		28a. Date of Injury (Month, Dey Year) 28	Bb. Time of Injury	28c. Injury at Work?		w injury occurred	
andir auth. Or: At the fu	2 Accident investigation		М	1 ☐ Yes 2 ☐ No			
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Division o To the Hospital or Attanding Ph within 24 hours eiter death. To the Funeral Director: After th complataly filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physical Exami	eiclan: To the best of my knowled her: On the basis of examination and manner stated.	dge, death occurred nend/or investigation	d at the time, date and place n, in my opinion, death occu	e, and due to the ca rred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
To th To th comp				ec. License number	29	d. Date signed (Month	Day, Year)
	1 1/ LAC	MIN		D-44436	<	Sept. 01	2004
<i>F</i>	30. Neme and address of person who co Ashvinkumar J F	mpleted cause of death (Item 23 atel, MD 102	Be) (Type, Print) Paul M	ellon Ct St	e 102 W	Valdorf, I	MD 20602
4							12 20002

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** September 2004 Year Lemuel Dutrow Shafer 6:00 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Citizens Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth Dec. 28, 1913 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**X** M 2□ F Days Hours 90 213-42-2014 Mary Land Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits mer must be notified at Frederick Maryland Frederick Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8926 Walter Martz Road 21702 U.S.A. items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □ Yes XX No Baltimore, Maryland 21215-0036 ō White traumatic avent, the Medicul Exact Specify: 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 Dairy Farmer Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emmert L. Shafer Carrie E. Dutrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. nancy R. Routzahn, daughter 9008 Walter Martz Road, Frederick, MD 21702 other 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State crematory or other place Mount Olivet Cemetery Sept. 8, 2004 = 5 permit. Page Department of Important: If any injury or once. Frederick, Maryland `4 □Donation 5 □ Other (Specify) Reeney and Basford PA Funeral Home 106 East Church St., Frederick, MD M00255 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician antonsin disease or condition resulting in death) /Medical to (or as a consequence of) **Examiner** Sequentially list conditions, if any secting to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Division of Vital Records, P.O. Box 68760, P.O. Box flating Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has performe Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) s after death. 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) 2 D-1397/ September 7, 2004 30. N me an address of person who completed death (Item 23a) (Type, Print) Robert L. Kaufmann, M.D. 300 West Ninth Street, Frederick, Maryland 21701 istrar's Signature State Registrar

ian	1						ertificate	OI D	realli			Reg	g. No.	1.0	ZX411
Han	Н.,,	. Decedent's Name (	(First, Middle, La	ast)							2. Date of		Day	Year	3. Time of Death
ical	L	Frank	Ei	ker	St	oetzel					AUGI	JST_	25,		11:26A.
ner	48	a. Facility Name (If n	not institution, gi	ve street and	number)		4b. City, T	own, or L	Location o	of Death			4c. County	y of Death	1
۳		1231 FERN		Sex	7 Ago //n	yrs. last birthda		LEON	IARD If Under:	24 Hrs	8. Date o	4 Dieth	CALVE		alana (Chata as Fass
		Social Security Nur		56x 1x∏ M 2 □ I		Vrc		Days	Hours	Min.	(Montl	n, Day, 1	<sup>Year)</sup>	Col	place (State or Fore intry)
		379-86-457 Isual Residence of D			4						CCL.	19,	1902	vene	ezuela
		0a. State	10b. County		100	c. City, Town or	Location								10d. Inside City Lim
ctor	M	aryland	Calver	t		St. L	eonard								1 ☐ Yes 2 <b>X</b> ☐
Director	10	0e. Street and Numb					10f. Zip (		CO.			109	g. Citizen of		intry?
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3	1	1. Marital Status	d 2 Married	Armed	ecedent Ever Forces?	'in U.S.   1	<ol> <li>Was Decede If Yes, specific</li> </ol>	nt of Hisp by Cuban,	, Mexican	gin? (Spe i, Puerto	ecify Yes o Rican, etc	r No- .)		ce - Amer ick, White	ican Indian, , etc.
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			For State MACADHOO		•			ealth and M	lental Hyg	jiene	
		_	Registrar VETUHZUG Q		BMW,MbCo	Cer	tificate of L	Jeath	2. Date of Dear	eg. No.	3 Time of Death
	Physicia	an	Decedent's Name (First, Middle, L						Month	Day Year	12:30 P M
4	/Medic	al	Alfred Edgar S  4a. Facility Name (If not institution, g				Ab City Town or	Location of Death	August	13, 2004 4c. County of Deat	
	Examin	er	Prince George's		,					Prince Ge	
	Europe I				Age (In yrs. Ia	st birthday)	Chever1	If Under 24 Hrs.	8. Date of Birth	9 Birt	holace (State or Foreign
	Funeral Director		579-16-2979	1 XM 2 □ F	85	Yrs.	Months Days	Hours Min.	Feb. 14	1919 Sou	th Carolina
	0		Usual Residence of Decedent								
	show	_	10a. State 10b. County			Town or Lo					10d. Inside City Limits  XXX Yes 2 □ No
	8a-f	cto	D.C. N/A		Was	hingto					
	or 2	Director	10e. Street and Number				10f. Zip Code		1	log. Citizen of What Co	
	s 23s	rai	3710 Grant Plac		at Guar in II C	1121	20019	isaasia Origin? (Sa	acity Vas as No.	United Sta	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mendair Hygiene.  Mimportant: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Exemination must be notified at once.	by Funerai	11. Marital Status  1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	If Yes, Give	<sup></sup> N° 194	1	f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
Maryland 21215-0036	hour tural	ed b	15. Decedent's	Year or Date:	5.	16a. Deced	lent's Usual Occupa	ation		16b. Kind of Business/	Industry
Ç.	in 72	Completed	(Specify only highest s	rade completed)	-5.)	(Give	kind of work done of OO NOT use retired	during most of work	ing	100. 11110 01 000111000	
2	r tha	mo	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Edu	cator			Education	
ੲੰ	e files otha vent,	Be C	17. Father's Name (First, Middle, La	st)				18. Mother's Name	e (First, Middle, I	Maiden Sumame)	
<u> a</u>	should by	70 8	Alfred E. Simons	s, Sr.				Mattie	Phyllis	Garnett	
a	2 sho is ma is ma		19a. Informant's Name/Relationship							r, City or Town, State, 2	Zip Code)
	and ealth m 27 m 27 rer tr	1 4	William Nicholso					., Takoma			
altimore,	Pages 1 nent of H ant: If itea ury or oth		20a. Method of Disposition 411 kg		ite unit	metery, cren	sition (Name of natory or other plac			20c. Location - City or	Town, State
Ē	tant:		'4 □Donation 5 □Other (Spe		Ceda		l Cemeter			Buitland ,	
Ba	permit. Departr Imports any inju		21. Signature Funeral Service Lic	houpour	~					neral Servi ashington,	
	ř.		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus ly one cause on each	sed the death. h line.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	Dem	entia						Onset and Death
	/Medical		resulting in death)	a	as a conseque	ence of):					
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	si ad	Examiner	Sequentially list conditions, by Lecture Underlying Cause. Enter Underlying Cause (Disease or injury		as a conseque						
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8760,	icate be executed physician and s the burial-transit	aiE			ertens						
687	ficate phys s the	edicai		dP	or comb	1011					
Вох	Attending Physicien: The law requires that the death certificate be executed to death.  r death.  ector: Aller this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal	death 3□	Ectopic pregnancy	,		23d. Date of del Month	ivery Day Year
P.O.	the de ry the a ached f	ysic	1 Yes 2 No 9 Unknown	4∟Pregnani 9□ Unknowr	t at time of dea	atn 5L	Other (specify)				
ω, σ	s that ned b e deta	y P	Part II. Other significant conditions	contributing to deat	h but not resul	lting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Ď	w requires t been signe should be								1 🗆 Y	es 2A⊡No 3⊟Pr	obably 4 Unknown
ပ္လ	awre is bee 2 sho	Completed							24a. Was a	an 24b. Were au	itopsy findings available completion of cause of
æ	The I	E							perform	med?   death?	2□ No
ā	ian: rtifica ctor, p	BeC	25. Was case referred to medical examiner?		-			26. Place of Deat			
<u> </u>	hysic his ce I dire	2	1 ☐ Yes 2 🔀 No	Hospital: 1X Inpa		R/Outpatier	t 3□ DOA Oth	er: 4 🗆 Nursing Ho	me 5 Reside	ence 6 □Other (Spe	cify)
<u>_</u>	ing P		27. Manner of Death 1 △Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	Worl	k?	28d. Describe ho	ow injury occurred	
Sio	tendi leath. tor: A	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no		Jahren Akhar			Yes 2 □ No	Opt I continu (C	ter at and Mumber and O	( O No
-	- 9	Certification;	4 Homicide determine	ed 28e. Place of building,	, etc. <i>(Specify)</i>	ne, rarm, str	eet, factory, office		City or Town	treet and Number or Au n, State)	irai Houte Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the tuneral director, page 2	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the be aminer: On the basis	s of examination	vledge, deatl on and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier				29c. Licens	e number	2	29d. Date signed (Monte	h, Day, Year)
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(V	(a)		30. Name and address of person wh							01 12	
0			Mukemil Abdella			, (-, p.s.	3001	Hospital	20785		
	Sta	ate	31. Date filed (Month, Day, Year)		istrar's Signati	ure	,	• •			
	Regist	rar	AUG 23 2	2004	ever	B	Sporks				

		1 - For State Registrar	State of Ma		/ Depa	rtment o		and Mo		ene	Die.	20076
		Decedent's Name (First, Middle, Last)				mouto	or Boar		2. Date of Death	g. No. U	) 1-}	3. Time of Death
Physici /Medic		Clara Mae Spe	dden						Month -	26 -	Year	1005 M
Examin		4a. Facility Name (If not institution, give si	-			4b. City, To	wn, or Location	of Death		4c. County	-	
		Memorial Hospita				۶	21437	W		17	TUB	XO7
Funeral Director		217-36-0450	M 2K/F	(In yrs. last 88	Yrs.	If Under 1 \ Months C	Year If Under Days Hours	Min.	8. Date of Birth (Month, Day, Oct. 9,	Year) 1915		lace (State or Foreign try) ryland
land		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Loc	ation					1	Od. Inside City Limits
EA I the Maryland 1 tradition at	ector	MD Dorches	ter			Ca	mbridge	2				1 ☐ Yes 2 😿 No
SO STATE OF	by Funeral Director	10e. Street and Number 6034 Todd Point 1	Road			10f, Zip Co	ode 21 <i>6</i>	513	10	g. Citizen of U.S	What Coun	try?
Sea sea	ner	11. Marital Status	2. Was Decedent E		13. W	as Deceden Yes, specify	t of Hispanic O Cuban, Mexica	rigin? (Spec	rify Yes or No- lican, etc.)		ce - America	
Baltimore, Maryland 21215-0036  Permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Important: If them 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Experiment mant be netified at once.	1 by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yas 2 🕱 No If Yes, Give Year or Dates:	)	į .	□Yes 2			', 2',		whi	
215-C 215-C thin 72 h e. natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation co <i>mpleted)</i> College (1-4or 5+		6a. Decede (Give k life. D	ent's Usual C ind of work of O NOT use i	occupation done during mo retired)	st of workin	g 1	6b. Kind of B	usiness/Ind	dustry
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Maryland Maryland to 2 should be filt. Ith and Menital Ity 77 is marked oth treumatic event	Be	17. Father's Name (First, Middle, Last)  Leland C. Beckwit	<b>⊢</b> h						(First, Middle, M	aiden Suman	10)	
Ty State of Mark	2	19a. Informant's Name/Relationship (Typ			10h Mailia	A 44 /O			Compte			
Ma Nd 2 s lith an 17 1 s requir		Patricia Tolley	daughte						Route Number, Cambr	-		Code) 1613
Ire, stan item other		20a. Method of Disposition		20b. Place	e of Disposi	ition (Name	of	Da Da		Oc. Location -		
Page Page nent c		1 ■ Burial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)	moval from State			eward		8/29	/04	Cambrid	ige. 1	MD
Baltimore, permit. Pages 1 at Departit. Pages 1 at Important: If the Measury injury or othe once.		21. Signature of Funeral Service Licenses	•	-	22.	Name and A	ddress of Facil	lity The	omas Fur	neral H		
m goz a a		23a. Part VEnter the disease, or complic							bridge,		1613	
Physician /Medical Examiner	Examiner	snock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	d bro consequence	VASO ce of):	1.5	Decid		oopmatory union		1	Approximate Interval Between Onset and Death
76( e be	cai	that initiated events c. resulting in death) Last d.	Due to (or as a	consequenc	ce of):							
ds, P.O. Box 68' irres that the death certificat signed by the attending phy d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal dea	ath 3□E	Ectopic pregn Other (specif				23d. Dat	e of deliver	ry Day Year
rds, f	þ	Part II. Other significant conditions conti	ributing to death but	not resultin	g in the und	lerlying caus	e given in Part	l.				e cause of death?
ecord law requir as been si	Completed								24a. Was an	24b. V	Vere autop	sy findings available
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/ita	Be	25. Was case referred to medical examiner?						e of Death (	Check only one)			
Of V Physi this c	2	1 Yes 2 No Ho	spital: 1 Inpatient		Outpatient				5 Resident			)
On ding th. After	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day 1	Year)	b. Time of Injury		Injury at Work? 1 Yes 2	į.	d. Describe how	injury occurr	ad	
Division of Vital Records, I or Attending Physician: The law requires tatler death. Director: After this certificate has been signed in by the funeral director, page 2 should be continued.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, (Specify)	, farm, stree				f. Location (Stre City or Town,	et and Numbe State)	er or Rural	Route Number,
Division of To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral presents of the funeral presen	edical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	. On the basis of e	xamımation	dge, death o	occurred at the	ne time, date ar my opinion, dea	nd place, an	d due to the cau	se(s) and ma	nner as sta	ited.
o the o the omple	Med	one)  29b. Signature and title of certifier.	and manner state	d.	2 /		cense number			l. Date signed		
T FSF0		1 Comety	///	1.11	moin		115	66		8/2	7/0	1/
	Ì	30. Name and address of person who com	. /	th (Item 23a	a) (Type, Pr	rint)	11/0	00		1/6	10	7
		Ludwig Eglsede				Cynwc	ood Dr.	, East	on, MD	21601		
Star Registra	7	31. Date filed (Month, Day, Year) AUG 3 0 200	32. pegistrar	s Signature	los	ette s						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 27, 8:25 P M 2004 George Donald Shafer Aug. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Jefferson Frederick 1721 Gapland Rd. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth

Month, Day 2 Year) 1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign County)
 MD **Funeral** 1**X** M 2□ F 214-18-9654 85 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2√ No Frederick Jefferson Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21755 USA 1721 Gapland Rd. or Itema 23a Completed by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant of Health and Mental Hygiene. W. 1 Never Married 25 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White 3 ☐ Widowed 4 ☐ Divorced II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) farmer farming 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Myrtle Gant Oscar P. Shafer ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Ruth Shafer (Wife) 1721 Gapland Rd., Jefferson, MD Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ▼Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) ö Union Cemetery 9/1/04 permit. Page Department of Importent: If eny injury or Burkittsville, MD \* 4 □ Donation y S rvice Li nure of Donald B. Thompson Funeral Home 31 E. main St., Middletown, MD 21769 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or leart failure. List only only cause on each line. Immediate Cause (Final **Physician** Colon Cancer metastatic Hears resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisause or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D32073 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 Stern Kathleen 610 Ninth  $\omega$ . 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

Registrar

		1 = For State Registrar	State	of Marylar	-	artmen <i>rtificat</i>				ental Hy	giene Reg. No	nni.	20070
	**	1. Decedent's Name (First, Middle	e, Last)							2. Date of De Month	eath Day	Yea	S. Time of Death
Physi /Med		JOSEPHINE	MAE	SMITH						8	24	2004	0020
Exam	iner	4a. Facility Name (If not institution	n, give street and n	umber)		4b. City,	Town, or	Location of	of Death		4c.	County of De	eath
<u> </u>		McCready Memor			land frieth days	Crisi		If Under	24 Hrs	0. Data of Bi		merset	
Funera Directo		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs.	73 Yrs.	Months	Days	Hours	Min.	8. Date of Bi	931	9. B	sirthplace (State or Foreign Country) aryland
- 4	1	216-70-6397 Usual Residence of Decedent			7.5					3, 11,	130.		
yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
Mar a-f el	ctor	MD Worces	ster	Poo	comoke	City							1 ☑ Yes 2 ☐ No
th the	- ire	10e. Street and Number				10f. Zip					10g. Citi:	zen of What	Country?
death with the Maryland ms 23a or 28a-f ehow	E	1006 Market Str					21851					USA	
ar dea	Funeral Director	11. Marital Status	Armed F		J.S. 13.	Was Deced If Yes, spec	lent of Hi orly Cuba	ispanic Ori n, Mexicar	igin? (Spe n, Puerto I	city Yes or N Rican, etc.)	0-	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
rs aft	by F	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	If Yas, G	: 2 ፟⊠No Bive Dates:		1 🗌 Yes	2 🔀 No	Specify:				Specify: W	hite
I Z I Z I D-0000 filed within 72 hours after Hygiene. other than "natural", or lie ent, the Medical Expire.	ed	15. Deceden	it's Education			dent's Usua					16b. Kir	nd of Busines	ss/Industry
hin 7.	ple	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of wo DO NOT us	nk done d se retired	during mos	t of work!	ng			
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ite, IV		20a, Method of Disposition	(ddag:ree	20b.	Place of Dispo	sition (Nan	ne of	-		ate			or Town, State
ages nt of nt of rer o		1 Sunal 2 Cremation		n State	cemetery, cre dwill Me	,			0/27/	2004			City, MD 2185
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D Ped Time		My 10	ADO	1.00	l i	ins th	vay 1 inder	Melso a Ave	n Fui	neral I ocomoke	Home,	P.A.	21851
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea	th. Do not en	ter the mod	e of dying	g, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between
Physicia	n	Immediate Cause (Final disease or condition	AN	rancel	) R	hen	ma	toric	1	Arth	wit	5	Onset and Death
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OR DE / DU, Certificate be executed Iding physician and Ise as the burial-transit	dical		d										
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ord equire										1 🗆	Yes 2	₹No 3 🔲	Probably 4 Unknown
N 60 SIC	Completed									24a. Was	psv	24b. Were	autopsy findings available completion of cause of
at at a	P P									1 Yes	ormed2 2 No	death'	es 2 No
ysician: Th ysician: Th is certificate director, pag	Be	25. Was case referred to medica examiner?							of Death	(Check only	one)		
Physic Physic rthis c	2	1 Yes 2 No			ER/Outpatie			4 🗆 NU		ne 5□Res			pecify)
ding Ph ding Ph h. After th	lon:	27. Manner of Death 1 Natural 5 Pendir	'9	e of Injury onth, Day Year)	28b. Time o Injury	M 2	8c. Injury Work	rat ⟨? Yes 2□		8d. Describe	now injury	occurred	
VISION Attending ar death. rector: Afte	Icat	3 ☐ Suicide 6 ☐ Could		ce of Injury - At h	nome farm st			163 2		28f. Location (	Street and	Number or	Rural Route Number.
after Direc	Certification:	4 Homicide determ	buil	ding, etc. (Speci	fy)		, 011100				wn, State)		
Hospital or Attention     Hours after dealt     Funeral Director: etely filled in by the			ng Physicien: To ti										
UVISION OF VICA With the Hospite or Attending Physicien: To the Hospite of Attending Physicien: To the Funeral Director: After this certifica completely filled in by the funeral director;	edical	(Check only 2 Medical one)	Examiner: On the and ma	basis of examination	ation and/or in	_							
To the within To the comple	M	29b. Signature and title of certifie	"Sarel			290	License	number	1 1 2 9		29d. Date	signed (Mo	nth, Dey, Year)
							<u>v</u> .	241	42	_	8	- 25	-04
~ ~		30 Name and address of person	who completed ca	use of death (Ite	m 23a) (Type,	Print)	- 4	f.	7	MD	910	251	
C.T 0		16 UY- / WW	rel	S/ Ragistrar's Sign		cor	~ 0	e,		· · · ·	0(10	) )	
	State strar	31. Date filed (Month, Day, Year,	0 2004	A Sign	H 1	hood	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day 0652 M Charlotte Ann Todd 2004 23 /Medical August 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death YENINSULA REGIONAL MEDICAL 5A4136414 Mamico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sept. 9, 1934 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Country) Mary Land **Funeral** Days 1 ☐ M 2 ☐XF Hours 220-32-8409 69 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artiment of Heatih and Mental Hygiene. ortanit: If team 23s or 28s-1 ehow ortanit: If team 27 is marked other than "natural", or itams 23s or 28s-1 ehow injury or other traumatic event, the Modreal Examinar must be notified as injury or other traumatic event, the Modreal Examinar must be notified as 10d. Inside City Limits Director MD Dorchester Rhodesdale 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5640 Indiantown Road 21659 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Day Care Provider Child Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Arthur W. Jones, Sr. Catherine Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Wright/Daughter 29803 Standish Street, Easton, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department important: It any injury o Unity Washington Cem. 8/26/2004 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur, of Funeral Service Lie Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 Ma. Part. Enter the disease, or confplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shark, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gas bro entest na) Physician /Medical Due to (or as a consequence of): **Examiner** Corongry Sequentially list conditions, if any leading 15 in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consumulates of burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached Physi ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed/ certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: Injury 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 ☐ Homicide within 24 hours a
To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Bamesh Agarwal

31. Date filed (Month) Day, Year)

AUG 26

DHMH 17 Rev 1/2001

Harione

Box 68760

Division of Vital Records, P.O.

1315 S. Division St. Salisbury, md 2180

Les

32. egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-23-04

		1 - For State Registrar	State of Maryla		artment of F			Reg. No.?	3: Time of Death
Physic /Medi Examii	cal	Raul Perez To      Raul Perez To      Aa. Fecility Name (If not institution, give s  Mallard Bay Car			4b. City, Town, o		AUGUS!	Day Y	eer 2030M
Funeral Director		5. Social Security Number  5. Social Security Number  6. Sex  5. Social Security Number  1. Security Number  1. Security Number  6. Sex  1. Security Number  6. Sex	M aDE	i. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		<sup>h</sup> Year) 1937	Birthplece (State or Foreigi Country) unknown
ath with the Maryland 23s or 28s-f show	Director	10a. State 10b. County Dorchest		City, Town or Lo	Cam	bridge			10d. Inside City Limits 1   Yes 2 □ No
s 23s or 2		10e. Street and Number 520 Glenburn Ave		110	10f. Zip Code	21613		10g. Citizen of Wha	.A.
72 hours after death with the Maryland "natural", or Items 23s or 28s-f show idical Exeminer must be notified at	by Funeral	11. Marital Status  1 Marital Status  1 Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	i			(Specify Yes or No- erto Rican, etc.) uerto Rica	100	American Indian, White, etc. hispanic
within 72 ene. than na	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) Coltege (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	eation during most of v d)	working	16b. Kind of Busin	,
should be filed nd Mental Hygi marked other umatic event, iii	To Be C	17. Father's Name (First, Middle, Last) unknown				unkno		Maiden Sumame)	
12 ha 7			guardian	P. (	). Box 21	7, Camb	Rural Route Numbe ridge, MD	21613	
nit. Pages 1 and artment of Healt ortent: If Item 2 injury or other		20a. Method of Disposition  1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	SHIOA WHILL OHILL OF OHE		osition (Name of matory or other place of Cremato:		Date 30/04	20c. Location - Cit Salisbur	
permit. Page Department of Importent: If eny injury or once.		21. Signature Funeral Service License	e				Thomas Fur ambridge,		
Physician /Medical		23a. Pert 1 Enter the disease, or complic shock or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	An	ter the mode of dyin	ng, such as card	iac or respiratory ari	rest,	Approximate Interval Between Onset and Death
Examiner and inspiration and privial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):	Hent 1 Deunt 1 Lellitu	Antur Disens S	5.5		142 142 1044.
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ital or Attendurs after deathers al Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	rify)			City or Tow	n, State)	or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical	(Check only 2 Medicel Examin	ician: To the best of my kner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	vestigation, in my o	pinion, death oc	curred at the time, o	date and place, and	due to the cause(s)
Voir Con	Σ	29b. Signature and title of certifier  Michael T	Paddew W	UN	29c. Licens	200	-	August	29 2004
		30. Name and address of person who co	Packlew 1	am 23a) (Type,	Print) 02 (21/11	WS AU	e Herlo	k md	2643
St Regist	ate rar	31. Dáte filed (Month, Day, AGG 3	0 2004 Registrat's Sign		book				

			For State Registrar	State of Marylan	d / Depa		of He	ealth an		tal Hyg	iene	nnı.	200	100
			Decedent's Name (First, Middle, Last)					-	2. [	Date of Deat		009	3. Time of	Death
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- X	Funeral		CORSICA HILLS II 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year	ILLE If Under 24	Hrs. 8. 0	ete of Birth			olace (State or ntry)	r Foreign
	Director		218-20-3410	<sup>rM 2□F</sup> 80	Yrs.	Months	Days	Hours		Month, Day, $n \cdot 6$ ,				
	p ,		Usual Residence of Decedent  10a. State 10b. County	100 Cit	y, Town or Lo	oation							I Od. Inside Cit	by Limite
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	28a-f	Director	Maryland Queen Ann	ne's	Wye Mi	11s 10f. Zip C	ode			11	Do: Citizer	n of What Cour		<i></i>
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	Jeath Tre 23	Funeral	149 Rustic Acree	12. Was Decedent Ever in U	.S. 13.	Was Decede	679 nt of His	panic Origin	? (Specify	Yes or No-	USA 14.	Race - Americ		
9	or Ite	Ē	1 Never Married 2 Married	Armed Forces?  1 X Yes 2 □ No If Yes, Give	\$		1		Puerto Ricar	n, etc.)		Black, White,	etc.	
8	hours after death with the Maryland turel', or Iteme 23a or 28a-f show at Exercinet free notified at	d by	3 Widowed 4 Divorced	Year or Dates:		1 □ Yes 2 [	<b>A</b> NO	Specify:			Sp	ecify: Bla	ack	
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9	를 <del>것</del> 를 로		9 17. Father's Name (First, Middle, Last)		114	CK DII		8. Mother's	Name (Fire	st, Middle, A				
an	2 E 2 S	To Be	William Martin	Turner				Mar	_	tewart				
Maryland 21215-0036	S D E E	-	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (	Street ar					own, State, Zip	Code)	
	1 and 2 Health a tem 27 ls		Jean V. Turner /	wife	P.0	Box 1	2,	Wye M	ills,	Mary1	and	21679		
Baltimore,	of Heali of Heali Fitern 2 r other		20a. Method of Disposition		Place of Dispo	sition (Name matory or oth	of er place,		Date	1	20c. Locat	ion - City or To	own, State	
Ĕ	mit. Pege bartment o ortant: If injury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	Ca	pitol (	Cremat	ory	08	-24-2	004	Dove	r, Dela	aware	
alt	permit. Peges 1 Department of H Important: If ite eny injury or ot		21. Storature of Funeral Service License	90	22	Name and Renni	Address	of Facility	unera	1 Home				
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68760,	cate be executed physician and the burial-transit	dical Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):									
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I Records,		Completed							-	24a. Was ar autopsy perform 1 Yes 2	red?	4b. Were auto prior to coo death?	mpletion of ca	ivailable luse of
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	1'A-1					Death (Ch	eck only one	9)			
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Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, sti	reet, factory,	office			ocation (Str City or Town		umber or Rura	l Route Numb	er,
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			1 / Man	W >			D	37 93	6		817	17780	Y	
			30. Name and address of pe n who co	mpleted cause of death (Iter	¥ 1	Print)	YIV	. 0	hick	r.Ms	16	4/200		
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature	ask.								

				Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene
				1 - State Registrar Certificate of Death Reg. No. 1 28983
		Physici /Medic		1. Decedent's Name (First, Middle, Last)  WALLACE ELMER THOMPSON  2. Date of Death Month Day Year ALGUST 26 2001 0720
	70	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Talbot  Talbot
		Funeral Director		5, Social Security Number  6. Sex 1 M 2 F 87  7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 1 Year 1 Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4 UG 14 1917  9. Birthplace (State or Foreign Min.) 4 UG 14 1917  DELAWARE
		show ed al		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit
		death with the Maryland	Funeral Director	MD TALBOT EASTON  12 Yes 2 □ N  10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?
		th with 23a o	ai D	609 N. WASHINGTON ST. 21601 USA
		after death w or Items 23a	uner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
- )	9600	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene item 27 Is marked other than "neturel", or Items 23a or 28e-f shov other treumatic event, the Medical Exacultar must be notified at	by	1 Never Married 2 Narried 1 Never Married 2 Narried 1 Never Married 2 No 1 Never Married 2 Narried 1 Never Married 2 No 1 Never Married 2 Narried 2 Narried 2 Narrie
lce	21215-0036	id 2 should be filed within 72 hours af th and Mental Hygiene 27 Is marked other than "naturel", or treumatic event, the Medical Exam.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry
10	21	led wii lygien her th		8 0 SHOP MANAGER RETAIL AUTO SALES
Nallac	and	d be fi	o Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  MOLLY HUGHES
$\leq$	Maryland	shoul and Me s mark umati	To	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2	In.	ss 1 and 2 of Health s item 27 ls r other tre		CATHERINE H. THOMPSON/WIFE 609 N. WASHINGTON ST., EASTON, MD 21601
8	Jore	ages 1 nt of H :: ff ite		20a. Method of Disposition  20b. Place of Disposition (Name of cametery, crematory or other place)  20c. Location - City or Town, State
B	Baltimore	permit. Pages 'Department of H Importent: If ite any injury or of		1. Signature of Funeral \$ervice Licensee
E	Ã	Depare Important in any ir		FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
Thompson		Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between Onset and Death
		/Medical		disease or condition resulting in death)  a.   Orownly Army Diffnit  Due to (or as a consequence of):
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	P.O.	at the	Phys	9 ☐ Unknown
	rds,	quires then signed and signed and be d	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Onknown
	eco!	e law re has be	Completed	24a. Was an autopsy prior to completion of cause of death?
	la F	sicien: The law s certificate has b lirector, page 2 s	e Col	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
	Ϋ́	ysicie is cert directe	To B	examiner?  1   Yes   2   No
	0 [	ding Phys		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Work?
	Division of Vital Records,	To the Hospitel or Attending Physicien: The within 24 hours efter death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)
	Ö	pitel or ours eft ere! DI		
		n 24 ho	edicai	29a. Certifier  (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
		To the To the comp	ž	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
				1 Ch why / C With My ) 3/4 66 8/ C6/09
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  LUDWIG EGLSEDER M.D. 503 CYNWOOD DR EASTON, MD 21601
		Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature
		Regist	ar	AUG 2 7 2004 Sand A Mark

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Yeer Debora Treder 23, 2004 4c. County of Deeth /Medical August 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 14912 Wannas Drive Prince Georges Accoceek If Under 1 Year | If Under 24 Hrs. Months Days Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 뮺 🗆 F 48 Director 214-68-9938 October 14,1955 Washington, D.C. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or itams 23a or 28a-f show Examiner must be notified at Maryland Prince Georges Accoceek 1 ☑ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 14912 Wannas Drive 20607 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 27 is marked other than "... rraumatic even! Elementary/Secondary (0-12) College (1-4or 5+) 12 Bus Driver Public School System Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Glenn Chandler Virginia Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other trau 2008. Ruddy Treder/ Husband 14912 Wannas Drive, Accoceek, MD 20607 20b. Place of Disposition (Name of cametery, crematory or other place)
Georgetown University August 23
Medical Center 2004 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BELL LUNG CANCOR NON SMALL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending ph for use as t IF FEMALE 23c. If yes, out*co*me of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. detached signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate Division of Vital 2 No 1 Yes Attending Physician: Be ( funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes \_2 ☐ No 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending after death. 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital or within 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) MD 33109 ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person wh WASHING TON BE 20107 3900 HUAN'S RESERVERZ 120.40 31. Date filed (Month, Day, Year) AUG 3 0 2004 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. DOODE 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 24, 2004 12:00P M AUGUST JOSEPH THURMAN TURNER /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner LARKIN CHASE HEALTH CARE BOWIE PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XX M 2□ F Months Days Hours Yrs. Director Q/i MARCH 10, 1910 WASHINGTON, DC 579 01 1869 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show ral', or items 23a or 28a-f shov Examiner must be mutilled at XX Yes 2 No Director WASHINGTON DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1100 47TH PLACE NORTHEAST 20019 UNITED STATES filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Specify: Completed by XX Widowed 4 ☐ Divorced BLACK "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, I'm Madical 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8TH BRICK MASON PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental ty Important: If item 27 Is marked oth any jiny or other traumatic eveni 2008: Be DANIEL TURNER BEATRICE JOSIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 307 DUNNVILLE PLACE UPPER MARLBORO, MD 20774 JEAN T. JONES / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1XX surial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL PARK 30 AUG 2004 LANDOVER, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician CORONARY ARTERY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PERIPHERAL VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events ding physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 Yes 2 No 9 Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably XX Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has page 2 certificate Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) OtherXXX Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XX No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury XX Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident nin 24 hours after death the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö TXX entifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title d ertifie

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records. P.O. Box 68760,

31. Date filed (Month, Day, Year)

AUG 3 0 2004

32 Registrar's Signary

30. Name and address of

ADITYA CHOPRA, M.D.



on who completed cause of death (Item 23a) (Type, Print)

D57028

600 RIDGELY AVE. #231

8-27-04

ANNAPOLIS, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2004 4:02PM DORIS TAYLOR 16, Aug. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 26725 Mt. Vernon Road Somerset Princess Anne If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1 M 2 M 87 219-03-5874 July 16. 1917 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Be Completed by Funeral Director Maryland Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26725 Mt. Vernon Road 21853 U.S. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife none Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clark I. Simms, Sr. Dorothy Bounds 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Graham Taylor, Sr. 26725 Mt. Vernon Rd., Princess Anne, Md. 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Asbury UM Cemetery \* 4 □ Donation 5 □ Other (Specify) 08/19/04 Mt. Vernon, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home, P.A. **7** MOO295 11673 Somerset Ave., Princess Anne, Md. 21853 J. Hins 1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeliate Cause (Final resulting in death) Due to (or as a consequence of): hyonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by mounto sos 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Z. Badros, M.D., 813 B. Eastern Shore Drive, Salisbury, MD 21804

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

AUG 2 6

2004

**Funeral** 

Director

ir then "naturel", or iteme 23e or 28e-f ehow the Medical Examiner must be notified at

death with the Maryland

filed within 72 hours after

Pages 1 and 2

i Hygiene.

and Mental h eq pinous

Health Item 27

permit. Page Department of Important: If any injury or

Physician

/Medical

**Examiner** 

burial-transi

the as use

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detached

should be

signed by

has page 2

certificate

attending physician

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

Hospital or Attending Physician: neral Director: After this certific filled in by the funeral director,

To the

death.

within 24 hours after death To the Funeral Director:

other traumatic event,

ö

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 0/2 1- State Registrar 2 Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **ITALTA** THELEMAQUE / Month Year **Physician** 3004 ALIA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S DOCTORS HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 216-49-8186 69 Director Jan 2, Haiti Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 27 Ia marked other than "natural", or Itema 23a or 28a-f show traumatic event. The Modical Examinat must be motified at 1 TxYes 2 □ No Directo Prince George's Mitchellville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2109 Waterleaf Way United States Funera 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 12 should be filed w h and Mental Hygier 7 Ia marked other th 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Telima The lemaque Erniza St. Fort 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 Paulette Berrette/Daughter 2109 Waterleaf Way Mitchellville MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Department of Important: If it any Injury or o 1 

Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven MD 8/21/2004 Silver Spring ^ 4 ☐ Donation 5 ☐ Other (Specify) Cemetery
22. Name and Address of Facility
22. Pol Signature of Funeral Service Licensee Elono Alexander S. Pope Funeral Home 2617 Penn Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARRHYTHMIA Physician /Medical Due to (or as a consequence of): HYPOTENSION Examiner Sequentially list conditions, Due to (or as a consequence of) Examine tany leading to immedicause. Enter Underlying Cause (Disease or injury use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown SUPRA SELLAR BRAIN TUMOR Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? OF PILMONARY autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Tes 2 XNo this 27. Manger of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the I To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Thelem ague

State Registrar

DOCTORS

Community HOSPITAL 8118 GOOD LUCK RD LANHAM MD 2070 31. Date filed (Month, Day, Year) . Registrar's Signature AUG 2 0 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0057636

PATRICIA EBEN.M.D.

8/16/200A

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 0000 2. Date of Death 3: Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** August 27 2004 11:05 a<sup>™</sup> James Orville Willey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 3881 Landon's Point Apt. 13 Crisfield Somerset If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 26, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 F Yrs. 1926 77 Maryland Director 220-12-1689 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Madical Expressment has be reciliated at 1 Yes 2 □ No Director Somerset Crisfield 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3881 Landon's Point Apt. 13 21817 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: white Š WWII 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) forest ranger state government es 1 and 2 should be filed w of Health and Mental Hygie f item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Solomon Rastall Willey Edith Insley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum 8047 Hull's Creek Rd., Westover, MD Donna Snyder daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1√∏Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Old Trinity Churchyard 8/31/04 Church Creek, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signatur soff-uneral Service Ecensee 700 Locust St., Cambridge, MD hors 23a. Part /Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 10 Months Lung Cancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Clie to (or as a consequence of) Examiner lany, leaving to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the attending physician and the for use as the burial-transit certificate be executed Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the at d be detached for ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has page 2 certificate 2 NO 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2**X** No 1 Yes 2 this in by the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death After 1 Certification Hospital or Attending 5 Pending investigation 1 Natural м 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours after on Funeral Direc 4 Homicide filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the within 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifit 0 D0015715 8.29.04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRISTIEN MD BURTON AVE. WILLIAM GILL 76423 2004 32. Recontrar's Signature 31. Date filed (Month, Day, Year) AUG 3 0 State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Bruce Bennet Wile 04-4435 Unk 04-4435

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Decedent's Name (First, Middle, Last)			2. Date of Deat	h	3. Time of Death			
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rage.	/Medic Examin		4a. Facility Name (If not institution, give street and numb	er)	4b. City, Town, or Location of Dea		4c. County of Death				
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	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday			9. Birth	place (State or Foreign			
	Director		578 86 3028 1 <sup>-1</sup> x <sup>2-F</sup>	41 Yrs.	Months Days Hours Mill	April 1		**			
	P.		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	anation			10d. Inside City Limits			
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	Me M	ecto	10 Company Number		10f. Zip Code	1/	0g. Citizen of What Cou				
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	S = 01 L	-	Dorwin Bruce Wile- fat	20b. Place of Disp	Park Chesapea						
Baltimore,	ges 1 au t of Hea lfitem or othe		20a. Method of Disposition 1 □ Burial 2 ②Cremation 3 □ Removal from St.	cemetery, cre	ematory or other place) July litan Funeral	8 2004	20c. Location - City or To	own, state a Virginia			
Ë	permit. Pages 1 Department of H Importent: If ite eny Injury or ot once.		' 4 □ Donation 5 □ Other (Specify)			DCT VICE?	TEXALIGITE	a virgini			
3a	permit Depar Impor eny Ir		21. Signature of Euneral Service Licensee		2. Name and Address of Facility Ra	usch Fur	neral Home	e PA			
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			snock, or near tailure. List only one cause on each			ic or respiratory arre	St,	Interval Between Onset and Death			
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	and al-tra	xar	that initiated events resulting in death) Last	as a consequence of):							
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89	£ 5 m	Physician/Medical					7				
Вох	eath certific attending p	/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco		☐Ectopic pregnancy		23d. Date of delive	,			
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Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of building	Injury - At home, farm, st , etc. <i>(Specify)</i>	treet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rura , State)	I Route Number,			
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	To the Hos within 24 ho To the Fun completely f	Med	one) and manne  29b. Signature and title of certifier	stated.	29c. License number	29	d. Date signed (Month,	Dav. Year)			
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					OCME		July 7, 200	J <del>'4</del>			
			30. Name and address of person who completed cause	ordeath (Item 23a) (Type Asst. M.E.	111 Penn St	Ralto	, MD 21201				
	Sta	te	Zabiullah Ali, M.D. A. 31. Date filed (Month, Day, Year)	istrar's Signature	TII FEIII St	. Darto.	, ru/ 21201				
	Registr		SFP 1 3 2004	istrar's Signature							

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	Physici	an	1. Decedent's Name (First, Middle, Last)						Date of Death Month JUGUST	Pay 20	X'ear	3. Time of Death
	/Medi Examir		Jesse E. Willard  4a. Facility Name (If not institution, give s	street and number)		4h City To	wn, or Location of		406051			4:30 P M
	Exami	ier ·	3205 QUEENSTOWN R			227	VT RAINI			4c. County		ORGES CO
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 \	fear If Under	24 Hrs. 8.1	Date of Birth			place (State or Foreign
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	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, I've Medical Exament in matter in cliffed at	Funeral	11. Marital Status	12. Was Decedent Ev Amed Forces?	ver in U.S. 13.	Was Deceden	t of Hispanic Ori Cuban, Mexican	gin? (Specify	Yes or No-		- Americ k, White,	an Indian,
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215	hin 7:	Completed	(Specify only highest grade	College (1-4or 5+)	(Give	kind of work a DO NOT use r	lone during mos	t of working		D. Kind of Bu	3111033/1110	Justry
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Exams or invatice recilled at once.		Mary E. Uchima - S  20a. Method of Disposition		20b. Place of Dispo	sition (Name of	of	9, N.		34 Ta:		Springs, FL
9	Pages ent of nt: If i		1 M Burial 2 ☐ Cremation 3 ☐ Re  1  Other (Specify)	emoval from State	Fort Line	-		0/20/2				
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service License	9	, 22	. Name and A	ddress of Facility	y Gasch	oo4 ві 's Fune	ral H	ome	aryland P Δ
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	be executed icien and burial-transit	Examiner	Sequentially list conditions, i.e., i.e. or growth in moders cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.		consequence of):							
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687	ificate g phys as the	edic	_ d.									
.O. Box	requires that the death certificate be executed een signed by the attending physicien and hould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of 1 Live birth 2   4 Pregnant at tin	Fetal death 3	Ectopic pregn Other (specify				23d. Date Mon		ry Day Year
ds, P	ires tha signed I be det	by	Part II, Other significant conditions con	ributing to death but i	not resulting in the ur	derlying cause	gyen in Part I.		_	_	A	e cause of death?
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	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	ospital:	2 ER/Outpatien	3□ DQA	04-	of Death (Ch				
o		F 1	27. Manner of Death	28a. Date of Injury	28b. Time of		njury at Work?		5 🗌 Residenc Describe how			SCENE
io	를 수 수 할	atio	Natural 5 ☐ Pending investigation	(Month, Day Y	ea <i>r)</i> Injury		Work? 1 □ Yes 2 □ N					
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	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☑ Medical Examin	cian: To the best of r er: On the basis of ex and manner stated	camination and/or inv	occurred at the estigation, in n	e time, date and ny opinion, death	l place, and d h occurred at	ue to the caus the time, date	e(s) and man and place, a	ner as sta nd due to t	ted. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	^			ense number			Date signed		
	0 11		Wirlen	N()			CME			AUGUST	25,	2004
R_	6) 19	1	30 Name and address of person who con	rpleted cause of deat	h (Item 23a) (Type, I	111	Penn St	treet,	Baltim	ore, M	aryla	and 21201
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's	Signature	**						

			1 - For State Registrar	State of Marylar	_	artment rtificate			and M		giene Reg. Ne	000	-	28991
Е	Physici	an	Decedent's Name (First, Middle, Last,     TT		T 7	1 0				2. Date of De. Month	Da	ay Y	ear	3. Time of Death
>	- /Medi	cal	Henry	Loui	LS WOO	od, Sr				Aug 29	, 20	004		11:07 A <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, give Southern Maryla				1int	Location o	of Death		40	County of Prin		George's
	Funeral Director			7. Age (In yrs. 72	last birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Aug 9,	h y, Year 193	32	Count	lace (State or Foreign try) Sinia
	yland Now		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation							10	Od. Inside City Limits
	e Mar la-f st	ctor	Maryland Prince (	George's	Upper	Mar1b	oro							1 □ Yes 2 XX
	with th	Director	10e. Street and Number 9907 William	nsburg Drive		10f. Zip (	Code 2077	'2				tizen of Wha		,
	death ms 23	Funeral		12. Was Decedent Ever in U	.S. 13.1				gin? (Spe	cify Yes or No- Rican, etc.)		ited		
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rylan	2 should be i and Mental I Is marked o eumetic eve	To Be	Thomas Wood  19a. Informant's Name/Relationship (Ty	no Printh	406 44-10-				Anni	(First, Middle, Le Balo	1			
Ma	r t z		Dallas Wood (Wife)							Route Number				<sup>Code)</sup> MD 20772
ore	Pages 1 a nent of Hes int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	lace of Dispo emetery, cren	natory or oth	e of ner place	ρ) Δ1		ate t 30,	20c. L	ocation - Cit	y or Tov	wn, State
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ord	w requir been si should	eted								1 🗆 Yı		<b>X</b> No 3□	] Probai	bly 4 🗆 Unknown
al Records,	The far ate has page 2	Completed						· -	_	24a. Was a autops perform	y _	24b. Were prior death	to comp h?	sy findings available pletion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:						(Check only on				
oţ	Phys this aldi	To L	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of		Other c. Injury	4   14013		e 5 ☐ Reside			Specify)	
ion	Attending at death. ector: After by the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М	Work?	es 2∐No			· · · · · · · · · · · ·	, 00001100		
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Di	31001	W	30. Name and address of person who con		SURE	nnt)					LIN	TON		Da0735
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			1 - State Registrar		Ce	rtificate	of Death		Reg. Ng.	2004	28992
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De		Year	3. Time of Death
*	/Medic			Wisooker, Jr	•			Aug	Day 2	2 800	
	Examir	er	4a. Facility Name (If not institution, give :	$\alpha_1, \alpha_2, 1$		4b. City, T	own, or Location of Deal		4c.	County of Dea	ith 1
			3740 Beach & Social Security Number 6. Security Num	7. Age (In yrs.	last hirthday)	If Under 1			*h	14 14	rthplace (State or Foreign
н	Funeral Director			XM 2□F 69	Yrs.		Days Hours Min		y, Year)	C	shington, DC
	D		Usual Residence of Decedent					10-0-1.	734	vva	
	anylar show	7	10a. State 10b. County		y, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 💆 No
	the M	Director	Maryland Anne Arus  10e. Street and Number	ndel		10f. Zip (	Edgewater		10a Citi	zen of What C	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event. The Medical Examinant Periodifical at ODGE.	2	3740 Beach Drive B	lvd.			21037		rog. Oiti	USA	ountry:
	death ms 2;	Funeral		12. Was Decedent Ever in U	.S. 13.		ent of Hispanic Origin? (S fy Cuban, Mexican, Puer	Specify Yes or No	-	14. Race - Am	
ထ္	after or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 224No If Yes, Give	ì	ir Yes, speci 1 □ Yes 2		to Hican, etc.)		Black, Whi	white
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Ϋ́	in 72 i "nat	olete	15. Decedent's Edu (Specify only highest grade	e completed)	(Give	dent's Usual kind of work DO NOT use	Occupation done during most of wo e retired)	rking	16b. Ki	nd of Business	s/Industry
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g	at Hyg	BeC	17. Father's Name (First, Middle, Last)					me (First, Middle			
<u>  a</u>	ould b Menta arked	ToE	Louis Alle	en Wisooker,	Sr.		Nell	ie Mae N	1cDar	niel	
Maryland 21215-0036	2 shc and Is m		19a. Informant's Name/Relationship (Ty				(Street and Number or R				Zîp Code)
	1 and Health Bm 27 ther t		Steven S. Wisooker, 20a. Method of Disposition				en Avenue, E	d jewater	•	21037 cation - City or	Town State
Baltimore,	ages nt of I t: # it		1 ☐ Burial 2 【X Cremation 3 ☐ R  `4 ☐ Donation 5 ☐ Other (Specify)	IBITIOVALITOTII STATE	Place of Disponentery, crea			6-04		gewater	
	nit. P artme orten injur.		21. Signature of Funeral Service License		las Cre		Address of Facility Ge				
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k 68	e as t	Physician/Med	IF FEMALE:							5.10	
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σ.	The law requires that the death certifica tie has been signed by the attending phoage 2 should be detached for use as the	by Ph	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	nderlying ca	use given in Part I.	23e. Did t	obacco u	se contribute to	o the cause of death?
Records,	w requires that been signed b should be deta							10,	/es 2[	□No 3 121€	robably 4 Unknown
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Vital	Physicien: The lithis certificate har all director, page	Be (	25. Was case referred to medical examiner?					ath (Check only o			
of/	Physic this c	2	1200		ER/Outpatier			lome 5 Resid			ocify)
	ding f h. After funer	tion	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe I	now injury	occurred	
Division	Attender deatlector:	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he							ural Route Number,
á	s after	Certification:	4  Homicide determined	building, etc. (Specif	y)			City or Tov	vn, State)		
	To the Hospitel or Attending Physical and the Computer of the Tothe Funeral Director: After this completely filled in by the funeral di		29a. Certifier 1 Certifying Physical Examin	sician: To the best of my kno ner: On the basis of examina	wledge, death	h occurred a	t the time, date and place	and due to the	cause(s)	and manner as	s stated.
	the H in 24 the F nplete	Medical	one)	and manner stated.							``
	To To	~	29b. Signature and title of certifier	1			License number			e signed (Mont	
			30. Name and address of person who co	amplete varues of death (from	23a) (Tuno	Print)		/	0	109	107
			William P	JONES,	ele D	6	00005 95 Am	erici	4	210	36
	Sta		31. Date filed (Month, Day, Year)	32. 9 gistrar's Signa	iture						
18	Registi	ar	ALIG 2 5 20	U4 Between	IF A	market					

Jaquan Ward Unpend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23a, 27, 28a-f per me G836 10-14-04 tas
State of Maryland / Department of Health and Mental Hygiene 04 - 5355AKG Amended item 1- State # 7,10c, &20b, per F. Home, Certificate of Death 8/27/04, WCHD, E.T. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jaquan Maleik Ward August 19, 2004 1:28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year I funder 24 Hrs. If Under 1 Year I funder 24 Hrs. Months Days Hours Min. (Month, Day, Year) 04/20/04 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√ M 2□ F Yrs. 216-69-7424 MDDirector Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits a 23a or 28a-f show Yes 2 □ No MD Princess Anee Anne Directo Somerset 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21853 11620 Freetown RD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or itema 11. Marital Status the Medical Examiner: Black, White, etc. filed within 72 hours after Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Specify: Specify: Black δ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If Item 27 is marked other t jury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Shanette S. Austin Kakaverial Ward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lisa Austin, grandmother 11620 Freetown RD Princess Anne, MD 21853 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory of other place)
a's Chappel Cemetery 08/26/04 Horntown, VA 1 ☐ Burial 2 ☐ Cremation 3 ☐ 5
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. Doa. 21 eignature of Funeral S 22. Name and Address of Facility Cooper & Humbles Funeral Co., Accomac, VA\_23301 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death 3a. Part . Enter the dis List only one o mediate Cause (Final Sudden Unexplained Death in Infancy(SUDI) **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine death certificate be executed burial-transit that initiated events physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year ō Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, should be d þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of cate hes page 2 s deaur: 1 Yes 2 No 1 XYes 2 No or Attending Physician; director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1√ZyYes 2 No 1 Inpatient % ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Infant in crib with large 28b. Time of 27. Manner of Death Certification: After Faund P<sup>M</sup> 1 Natural 5 Pending 1 ☐ Yes 2 No s after death. investigation 8-19-04 blanket and sofa cushion 2 Accident the 6 Carolid not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number of Rural Route Number, Rd City or Town, State) 11620 Freetown Rd filled in by 4 Homicide Residence Princess Anne, Somerset Co., MD Fo the Hospital within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific O.C.M.E. August 20, 2004 30. Name and address of person who completed c use of death (Item 23a) (Type, Print)  $\mathcal{C}$ 12. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

AUG 2 7 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2004 5:00 AM Younkins August 22 Thurston Eugene /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick 11010 Liberty Road Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Year)

Months Days Hours Min. April 19, 1932 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 X M 2 □ F **Funeral** Months Maryland 212-24-5340 72 Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2/☐ No Frederick Director MD Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21701 U.S.A. 11010 Liberty Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. mit. Pages 1 and 2 should be filed within 72 hours atter bartment of Health and Mental Hyglene. cortent: if item 27 ie marked other than "natural", or ite injury or other traumatic event, the Medical Examinal 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) site development/ College (1-4or 5+) Elementary/Secondary (0-12) paving/excavating heavy equipment operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ruth Morgan Carmie Earl Younkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11010 Liberty Rd., Frederick, MD 21701 Betty K. Younkins - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Prospect Cemetery 8/25/2004 Mount Airy, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee Hartzler Funeral Home 22. Name and Address of Facility 11802 Liberty Rd., Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): mouths **Physician** CaNCRS /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 Unknown Palmenary DISPLASE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 st autopsy perform 1 ☐ Yes 1 ☐ Yes 2 ☐ No 20 No Physician: after death.

Director: After this certific
I in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 1 Tes 28 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Hospitei or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cai (Check only one) and manner stated. within 2 To the F the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8-23-04 WIL MO MO 51610 Tolina 3+2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Tolino 21707 AUR Tred 85:44 Smite Takey 1475 31. Date filod (Month, Day, Year) AUG 2 6 32. Registar's Signature State 2004 Blown & Sparke Registrar

State Registrar

31. Date filed (Month, Day, Year) SEP 1 4 2004

Whate

MARYDONOD

KDREU 32. Registrar's Signature

rell

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 04, 2004

		1 - State Registrar  1. Decedent's Name (First, Mic				rtificate of		Mental Hyg	g. No. () ()	28996
Physici /Medic Examir	al	Franklin A 4a. Facility Name (If not institut	. Ackwi			4b. City, Town,	or Location of De	September	Day Year 2004 4c. County of Deal	h
		Johns Hopkins 5. Social Security Number	Bayview				more		Battimor	
uneral irector		213–20–7359 Usual Residence of Decedent	6. Sex 1 <b>M</b> M 2 □ F		s. last birthday) Yrs.	If Under 1 Year Months Days		Irs. 8. Date of Birth (Month, Day, April 24	9. Bin Co 1925	hplace (State or Fore nuntry) MD
tal		10a. State 10b. Cour	-		City, Town or Lo					10d. Inside City Lin
8a-f s	ecto		imore	S	parrows					1 ☐ Yes 2 ☑
la or 2	Dir	10e. Street and Number 2122 Lodge For	crost Driv	<b>7</b> 0		10f. Zip Code 21219	,	10	0g. Citizen of What Co	untry?
ms 2;	nera	11. Marital Status		ecedent Ever in Forces?	U.S. 13.			(Specify Yes or No- erto Rican, etc.)	USA 14. Race - Ame	
Department of regards and without rygeting institute!, or flems 23a or 28a-f show findportant; if flem 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Micalical Examinar must be notified at once.	Completed by Funeral Director	1 Never Married 2 M M 3 Widowed 4 Divorc	arried 177 Yes	s 2 □ No 3ive		TYes, specify Cut		erto Rican, etc.)	Specify: W	hite
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parked o	2	August A. Ackv					Mamie	M. Bearma	n	
tem 27 Is ma		19a. Informant's Name/Relatio Magaline Ackwi		wife	2122	Lodge Fo			City or Town, State, 2 rows Point	
ant: If ite		20a. Method of Disposition  1X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other		m Ctota	Place of Dispo cemetery, cren udon Pa	natory or other pla		ptember	20c. Location - City or Baltimore,	
Important: I any injury o once.		21. Signature of Funeral Service	ce Licensee		22 C 7	Name and Address onnelly 110 Soll	ess of Facility Funeral ers Poir	Home Of D	undalk,P.A undalk,MD.	*21222
sician and purial-transit	ш	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	o (or as a conse	quence of):					
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sign d be	by	Part II. Other significant condi History of Lef			_				acco use contribute to	the cause of death bably 4 Unkn
certificate has been rector, page 2 shoul	Completed	Hypertension,		Mellit	15			24a. Was an autopsy perform 1 Yes 2	prior to c	opsy findings avail ompletion of cause 20 No
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ctor:	Certification:	3 Suicide 6 Could 4 Homicide deter	mined 288. Place	e of Injury - At h	nome, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
n Di	edical (	29a. Certifier (Check only one) Certify	il Examiner: On the	e best of my kn basis of examina nner stated.	owledge, death ation and/or inv	occurred at the til estigation, in my o	me, date and place opinion, death occ	ce, and due to the cau curred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
he Funeral Dir pletely filled in	ed					29c. Licens	e number	290	d. Date signed (Month,	Day Year)
To the Funeral Dire completely filled in b		29b. Signature and title of certif	re Conne	I, MD		Res	- 000	Se	ptember 12 21224	2,2004

Frederick Anderson Sr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item#22, per FH, C835, 9/14/04 TT

State of Maryland / Department of Health and Mental Hygiene 04 - 5788DOS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** FREDERICK ANDERSON SR. September 8, 2004 1112 a<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA Mercy Medical Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 158M 2□F 216-60-8836 Yrs. MD Director 03.16.1952 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d, Inside City Limits or 28e-f show other treumatic event, the Madical Examiner must be notified at MD 1 ☐ Yes 2 ☐ No BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2946 ARUNAH AVENUE 21216 USA "natural", or Items 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. hours efter 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: PLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "na eny injury or other treumatic event, Ite Madic once. College (1-4ar 5+) Elementary/Secondary (0-12) Factor supervisor 11th orade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CLARENCE ANDERSON, SR. NANNIE WALTERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1802 N. CALVERT STREET BALTO MD 21202 LINDA P. ANDERSON MIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State KING DARK 09.13.04 BALTIMORE, MD 4 Donation 5 ☐ Other (Specify) f Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICES 21229 5151 PALTIMORE NAT'L DIKE BALTO, MD 2124 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Complications of Chronic Alcoholism Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to himnediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atte should be detached for Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 VYes 2□ No 24a. Was an autopsy performed? 1 X Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 (Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 9, 2004 OCME Tamoly person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Southall, 111 Penn Street, Baltimore, Maryland 21201 tamela E 31. Date filed (Month, Day 32. Registrar's Signature State Ber Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 1640 DM **Physician** ANA POLSKY SEPTEMBER 9 2009 CHERNA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. NORTHWEST HOSPITAL 9. Birthplace (State or Foreign Country KRAINE 8. Date of Birth 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number 0270771910 **Funeral** 1□M 2₩F 94 219-92-7944 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Department of Health and Mental Hygiene. Internal, or items 23a or 28a-f show important: if item 27 is marked other than "natural, or items 27 is marked and any injury or other traumatic event. It a Medical Exercities must be notified at any injury or other traumatic event. It a Medical Exercities must be notified at any injury or other traumatic event. 1 Yes 2 No OWINGS MILLS BALTIMORE Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UKRAINE 21117 24 FOXCREEK COURT 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after WHITE □ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 ρ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) OWN HOME College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 is marked other than ' HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) UNOBTAINABLE MIRIAM CHIZHUK ABRAHAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) OWINGS MILLS, MD 21117 24 FOXCREEK COURT PHIL ANAPOLSKY / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 09/12/2004 OWINGS MILLS, MD ☐Burial 2 ☐ Cremation 3 ☐ Removal from State HAR SINAI \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Eduma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rocks gram negative disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** lostridium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): 40 Box 68760. by Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknow 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an 1 Yes 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No Inpatient Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of ate of Injury (Month, Day 27. Manner of Ceath After Injury 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No safter death. in by the 28f. Location (Street and Number or Rural Route Number City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide filled 24 hours a DEC Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0005 9736 MID. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD 5401 OLD 31. Date filed (Month, Day, Year) PERIRAY 32. Registrar's Signature SEP 1 4 2004 Registrar

4-58. 8.K.S			Unpend item #23	Type or Prir a, 27, 28a	nt in Black	G836,10/8	Finsure All	Copies A	Are Legible	·.	
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			Decedent's Name (First, Middle, Last	")		7		2. Date of Death	1	3. Time of Death	
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1275	Funeral Director		211-66-1702	7. Ag	e (In yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	1958 7	Birthplace (State or Foreign Country) 1ARYLAND	
7	and wc		Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr	or Location				10d. Inside City Limits	
	sa-f sho	Director	MARYLAND N.	/A			TIHORE		og. Citizen of What	1 X Yes 2 No	
	with the	Dire	10e. Sfreet and Number	OKFIELL	AVEIL	10f. Zip Code	2121	7	og. Citizen of What	SA.	
	death ma 23	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.		Hispanic Origin? (Spe ban, Mexican, Puerto F	cify Yes or No-		merican Indian, /hite, etc.	
36	72 hours effer death with the Maryland natural; or Itema 23a or 28a-f show dical Examinate must be motified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 2 1 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 █ <b>X</b> No			Specify:	LACK	
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event, the Medical Examiliset must be multiled at once.	Completed	Elementary/Secondary (0-12)	College (1-4or !	5+)	CHE I	F			REGENCY	
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Baltimore,	mit. P partme portan y injur		21. Signature of Funeral Service Licen		no.	22. Name and Add	- 1	MUN J	R. FUN	ERALITOME	
<u> </u>	permi Depa Impo any ir	isi i	Latuch	N. Wel	Munn	21407	J. FULTON	AVE.		MD - 21217 Approximate	
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	To the Hospital or within 24 hours afte To the Funerabbir completely filled in	edicai C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best niner: On the basis and manner s	of examination ar	e, death occurred at the dor investigation, in my	time, date and place, a y opinion, death occurr	and due to the ca ed at the time, da	ause(s) and manne ate and place, and	r as stated. due to the cause(s)	
•	To the l	Med	29b. Signature and title of certifier	helshi	ul-up	(	onse number O.C.M.E	2	9d. Date signed (N SEPT.	ionth, Day, Year) 11, 2004	
	/ Proje		30. Name and address of person who MAMMAMA		W 111 F	(Type, Print) Penn Street	, Baltimore	e, Maryl	and 2120	1	
	St Regist	ate rar	31 Date filed (Month, Day, Year) SEP 1 4 20	004 32 egist	trar's Signatur	Apole					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Miriam R. Bruns September 12, 10:50 AM 2004 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death 301 Gun Road Baltimore Baltimore 8. Date of Birth (Month, Day, Year JUN 18, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Months Days Hours Min Yrs 212-26-0658 90 Mary Land Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 301 Gun Road USA 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5 + Spring Grove Hospital Elementary/Secondary (0-12) Laboratory Technician 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Albert Rittenhouse Melinda Pauline Woodland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Giles/Daughter 127 Fernwood Drive, Portage, PA 15946 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 9/14/04 Baltimore, MD 21. Signalure of Funeral Service Licensee Cremation Society of MD, Inc. 299 Frederick Road Baltimore, Edward A. Gregorchik MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final nyolar disease or condition resulting in death) Acute Due to (or as a consequ Due to (c) as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death - 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an rmedz 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending

/Medical **Examiner** physician and the burial-transit Box 68760. attending f P.0. the signed by

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be

Examiner

Physician/Medical

Be Completed by

Certification:

Medical

**Funeral** 

Director

the Manyland

d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 7 is marked other then "natural", or Hems 23a or 28a-f show 7 is marked other than "natural", or Hems 23a or 28a-f show traumatic awant, Ira Mazica. Examinat must be untilized as

Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If item 27 is marked other t

Department of Health a Important: If itam 27 is any Injury or other trainonce.

Pnysician

Baltimore, Maryland 21215-0036

Hospital or Attanding Phyaician: The law requires that the death certificate be executed Division of Vital Records, nis certificate has bil director, page 2 sf ٩ this After death. Diractor;

within 24 hours a To the Funeral D

31. Date filed (Month, Day, Year) Registrar **SEP 1 4 2004** 

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

investigation

6 Could not be determined

MD Registrar's Signature 02823

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 □ Yes 2 □ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

September 13, 2004

BALL MD 21238 GUIDE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)